AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2022
April 2021 Meeting

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AMA
AMERICAN MEDICAL ASSOCIATION

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May 17, 2021

The Honorable Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Subject: RUC Recommendations

Dear Ms. Richter:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare & Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2022, CPT 2023* and to existing services identified by the RUC's Relativity Assessment Workgroup and CMS.

Enclosed are the RUC recommendations for all the CPT codes reviewed at the April 21-24, 2021, RUC meeting.

COVID-19 Immunization Administration
The CPT Editorial Panel has implemented CPT codes to describe immunization administration of vaccines developed by each of the following: Pfizer-BioNTech, Moderna, AstraZeneca, Janssen and Novavax. RUC recommendations related to Pfizer-BioNTech and Moderna were submitted to CMS in December 2020. We submitted our recommendations for immunization administration of the AstraZeneca in late January 2021 with the RUC comment letter on the Final Rule for 2021. We submitted the Janssen vaccine administration recommendations in February 2021. We are submitting the Novavax vaccine administration recommendation, along with all COVID vaccine administration recommendations to date with this submission.

CPT 2022 New and Revised Codes – *April 2021 RUC Submission*
The enclosed binder contains RUC recommendations, including those for new and revised CPT codes for CPT 2022. **The RUC submits work value and/or practice expense inputs for 25 new/revised/related family CPT codes from the April 2021 RUC meeting.**

CPT 2023 New and Revised Codes – *April 2021 RUC Submission*
The RUC submits work value and/or practice expense inputs for 38 new/revised/related family CPT codes for *CPT 2023* from the April 2021 RUC meeting.

Existing Services Identified by RUC and CMS for Review

In addition to the new/revised CPT code submission, the RUC submits recommendations for 15 services identified by the RUC or CMS as potentially misvalued and reviewed at the April 2021 RUC meeting.

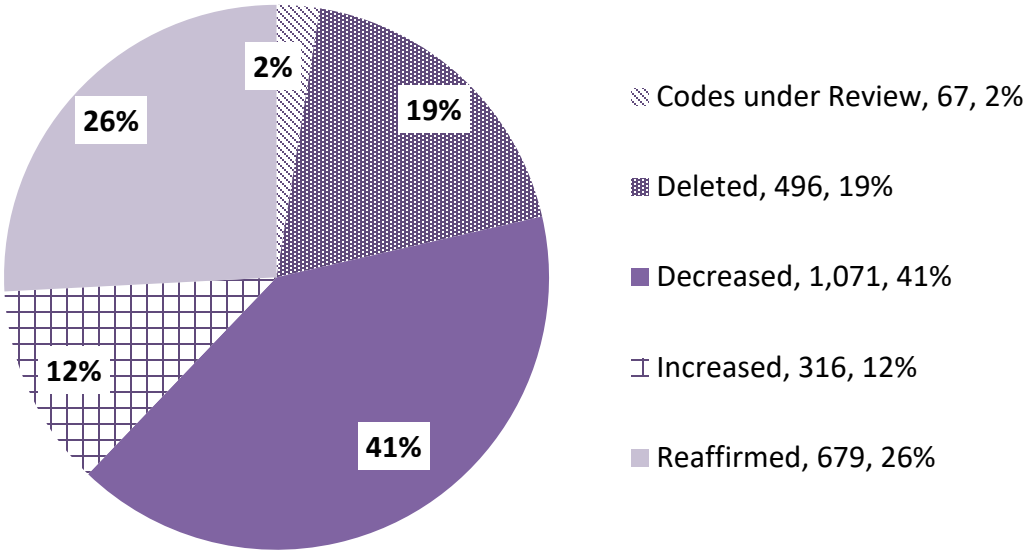
Office Visits Included in Codes with a Surgical Global Period

The RUC strongly believes that it is appropriate to apply the increased 2021 valuation of the office E/M visits to the visits incorporated in the surgical global packages. However, CMS proposes not to apply the office E/M visit increases to the visits bundled into global surgery payment. An example of the shortcomings of this policy decision became apparent during discussion of CPT code 67141 *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy* (RUC recommended work RVU = 2.53 and 2-99213 office visits) at the October 2020 RUC meeting. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes are being valued too low considering that office visits for the surgical global period are not going to be increased to the 2021 office E/M codes. Considering that the 99213 office visit in 2021 is valued at 1.30 RVUs two 99213 office visits are valued higher than the 2.53 value of this code. Therefore, the CMS policy is disadvantageous to the eye surgeons and an example of shortcomings and rank order abnormalities the flawed policy creates. The Agency's position implies that the physician work for office visits is not the same when performed in a surgical global period, which is an inaccurate assumption. **As stated in the RUC comment letter to CMS on the CY 2021 Proposed Rule, the RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard than others. The RUC urges CMS to apply the office visit increases to the office visits included in surgical global payment, as it has done historically.**

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since 2006, the RUC has identified 2,629 potentially misvalued services through objective screening criteria and has completed review of 2,562 of these services. The RUC has recommended that 60% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services.

Figure 1: AMA/Specialty Society RVS Update Committee (RUC) Potentially Misvalued Services Project



RUC Identified Potentially Misvalued Services

The RUC identified HCPCS codes G0407 *Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth* and G0408 *Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth* via the CMS/Other Source with Medicare Utilization over 20,000 screen. **The RUC agreed that there will likely be numerous changes in telemedicine utilization due to the pandemic, therefore recommended these services be reviewed in two years (April 2023) after additional data are available. Second, there should be a CPT Assistant article, if appropriate or other CMS education regarding who should be reporting these services. The RUC also would like to inform CMS of possible misreporting of these services. Based on the *Medicare Provider Utilization and Payment Data Physician and Other Supplier PUF CY 2018* data, seven to eight individual Nurse Practitioners account for approximately 50% of G0407 and G0408 services provided.**

Practice Expense Subcommittee

The attached materials include direct practice expense input (medical staff, supplies and equipment) recommendations for each code reviewed. As a reminder, cost estimates for proposed new clinical staff types, medical supplies and medical equipment (not listed as part of the CMS labor, supply, and equipment lists) are based on provided source(s), such as paid invoices and may not reflect the wholesale prices, quantity, cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing.

Basic Injection Pack Alternate

The RUC identified that for many services the use of Chloraprep (chlorhexidine) for intact skin preparation has become more typical than Betadine (povidone-iodine solution). There is one pack for basic injection, SA041 *pack, basic injection,* and 109 codes, covering multiple specialties, utilize this pack. This includes injection codes with utilization greater than 1 million. SA041 includes 10 ml

povidone solution (Betadine) that use remains typical for certain procedures because Chloraprep is not generally associated with the eyes, ears or genitalia due to its high alcohol content. The RUC determined that the best approach would be to create an alternative pack so that specialties can select the pack with the most appropriate antiseptic. **The RUC requests that the Centers for Medicare & Medicaid Services create an alternate basic injection pack to appropriately account for the typical antiseptic moving forward. The new pack should duplicate SA041 *pack, basic injection* with the addition of SJ081 *swab, patient prep, 1.5 ml (chloraprep)* and removal of supply items SJ041 *povidone soln (Betadine)* and SG009 *applicator, sponge tipped*.**

DESCRIPTION	Code	Unit	Item Qty
pack, basic injection	**SA041-Alternate**	**pack**	
swab, patient prep, 1.5 ml (chloraprep)		item	1
~~applicator, sponge tipped~~		~~item~~	~~3~~
bandage, strip 0.75in x 3in		item	1
cap, surgical		item	1
drape, sterile barrier 16in x 29in		item	1
drape, sterile, for Mayo stand		item	1
gauze, sterile 4in x 4in		item	2
gloves, sterile		pair	2
gown, staff, impervious		item	1
gown, surgical, sterile		item	1
lidocaine 1%-2% inj (Xylocaine)		ml	5
mask, surgical		item	1
needle, 18-27g		item	2
~~povidone soln (Betadine)~~		~~ml~~	~~10~~
syringe 3ml		item	1
underpad 2ftx3ft (Chux)		item	1

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for *CPT 2022* and *CPT 2023.*
- RUC Recommendation Summary of Existing Codes Identified by CMS or the Relativity Assessment Workgroup.
- RUC Recommendation Progress and Status Reports for 2,629 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File – A list of the physician time data for each of the CPT codes reviewed at the April 2021 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions – The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.

- PLI Crosswalk Table – The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.

- BETOS Assignment Table – The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.

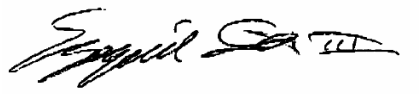
- Utilization Data Crosswalk – A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2023 conversion factor increase.

- New Technology List and Timeline – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 730 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.

- RUC Recommendations on Modifications to Visits in the Global Period – April 2021.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at Sherry.Smith@ama-assn.org.

Sincerely,



Ezequiel Silva III, MD
Chair, AMA/Specialty Society RVS Update Committee

Enclosures

cc:

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2022/2023

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CPT 2023 RUC and HCPAC Recommendations

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157X1	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C1	April 2021	09	ACS, ASCRS, SAGES	8.50	8.00		☑		☐
338X3	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A1	October 2021	04	ACC, SCAI				☑		☐
338X4	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A2	October 2021	04	ACC, SCAI				☑		☐
338X5	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A3	October 2021	04	ACC, SCAI				☑		☐
338X6	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A4	October 2021	04	ACC, SCAI				☑		☐
338X7	ZZZ	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A5	October 2021	04	ACC, SCAI				☑		☐
43235	000	F	Feb 2021	16	Endoscopic Bariatric Device Procedures	B1	April 2021	08	ACG, AGA, ASGE, SAGES	2.09	2.09	Yes	☑		☐
43X21	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B2	April 2021	08	ACG, AGA, ASGE, SAGES	3.40	3.11		☑		☑
43X22	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B3	April 2021	08	ACG, AGA, ASGE, SAGES	2.80	2.80		☑		☑
49560	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49561	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49565	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49566	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49568	ZZZ	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
49570	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49572	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49580	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49582	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49585	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49587	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49590	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49652	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49653	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49654	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49655	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49656	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49657	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49X01	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C2	April 2021	09	ACS, ASCRS, SAGES	6.27	6.27		☑		☐
49X02	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C3	April 2021	09	ACS, ASCRS, SAGES	9.00	9.00		☑		☐
49X03	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C4	April 2021	09	ACS, ASCRS, SAGES	10.80	10.80		☑		☐
49X04	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C5	April 2021	09	ACS, ASCRS, SAGES	16.65	14.00		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
49X05	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C6	April 2021	09	ACS, ASCRS, SAGES	17.00	14.88		☑		☐
49X06	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C7	April 2021	09	ACS, ASCRS, SAGES	24.24	20.00		☑		☐
49X07	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C8	April 2021	09	ACS, ASCRS, SAGES	7.75	7.75		☑		☐
49X08	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C9	April 2021	09	ACS, ASCRS, SAGES	10.79	10.79		☑		☐
49X09	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C10	April 2021	09	ACS, ASCRS, SAGES	12.00	12.00		☑		☐
49X10	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C11	April 2021	09	ACS, ASCRS, SAGES	18.50	16.50		☑		☐
49X11	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C12	April 2021	09	ACS, ASCRS, SAGES	18.53	16.97		☑		☐
49X12	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C13	April 2021	09	ACS, ASCRS, SAGES	25.00	24.00		☑		☐
49X13	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C14	April 2021	09	ACS, ASCRS, SAGES	15.50	14.24		☑		☐
49X14	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C15	April 2021	09	ACS, ASCRS, SAGES	20.25	18.00		☑		☐
49X15	ZZZ	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C16	April 2021	09	ACS, ASCRS, SAGES	5.00	5.00		☑		☐
64400	000	F	May 2021	14	Nerve Injections	M1	October 2021	05					☑		☐
64405	000	F	May 2021	14	Nerve Injections	M2	October 2021	05					☑		☐
64408	000	F	May 2021	14	Nerve Injections	M3	October 2021	05					☑		☐
64415	000	R	May 2021	14	Nerve Injections	M4	October 2021	05					☑		☐
64416	000	R	May 2021	14	Nerve Injections	M5	October 2021	05					☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
64417	000	R	May 2021	14	Nerve Injections	M6	October 2021	05					☑		☐
64418	000	F	May 2021	14	Nerve Injections	M7	October 2021	05					☑		☐
64420	000	F	May 2021	14	Nerve Injections	M8	October 2021	05					☑		☐
64421	ZZZ	F	May 2021	14	Nerve Injections	M9	October 2021	05					☑		☐
64425	000	F	May 2021	14	Nerve Injections	M10	October 2021	05					☑		☐
64430	000	F	May 2021	14	Nerve Injections	M11	October 2021	05					☑		☐
64435	000	F	May 2021	14	Nerve Injections	M12	October 2021	05					☑		☐
64445	000	R	May 2021	14	Nerve Injections	M13	October 2021	05					☑		☐
64446	000	R	May 2021	14	Nerve Injections	M14	October 2021	05					☑		☐
64447	000	R	May 2021	14	Nerve Injections	M15	October 2021	05					☑		☐
64448	000	R	May 2021	14	Nerve Injections	M16	October 2021	05					☑		☐
64449	000	F	May 2021	14	Nerve Injections	M17	October 2021	05					☑		☐
64450	000	F	May 2021	14	Nerve Injections	M18	October 2021	05					☑		☐
64451	000	F	May 2021	14	Nerve Injections	M19	October 2021	05					☑		☐
64454	000	F	May 2021	14	Nerve Injections	M20	October 2021	05					☑		☐
64455	000	F	May 2021	14	Nerve Injections	M21	October 2021	05					☑		☐
69714	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N1	October 2021	06	AAOHNS				☑		☐
69715	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		Deleted						☑		☐
69717	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N4	October 2021	06	AAOHNS				☑		☐
69718	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		Deleted						☑		☐
69X50	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N2	October 2021	06	AAOHNS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
69X51	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N5	October 2021	06	AAOHNS				☑		☐
69X52	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N7	October 2021	06	AAOHNS				☑		☐
69X53	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N8	October 2021	06	AAOHNS				☑		☐
69XX0	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N3	October 2021	06	AAOHNS				☑		☐
69XX1	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N6	October 2021	06	AAOHNS				☑		☐
69XX2	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N9	October 2021	06	AAOHNS				☑		☐
76942	XXX	R	May 2021	14	Nerve Injections	M22	October 2021	05					☑		☐
77002	ZZZ	R	May 2021	14	Nerve Injections	M23	October 2021	05					☑		☐
77003	ZZZ	R	May 2021	14	Nerve Injections	M24	October 2021	05					☑		☐
90785	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O1	October 2021	07	AACAP, APA, APA				☑		☐
90791	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O2	October 2021	07	AACAP, APA, APA				☑		☐
90792	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O3	October 2021	07	AACAP, APA, APA				☑		☐
90832	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O4	October 2021	07	AACAP, APA, APA				☑		☐
90833	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O5	October 2021	07	AACAP, APA, APA				☑		☐
90834	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O6	October 2021	07	AACAP, APA, APA				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90836	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O7	October 2021	07	AACAP, APA, APA				☑		☐
90837	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O8	October 2021	07	AACAP, APA, APA				☑		☐
90838	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O9	October 2021	07	AACAP, APA, APA				☑		☐
90839	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O10	October 2021	07	AACAP, APA, APA				☑		☐
90840	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O11	October 2021	07	AACAP, APA, APA				☑		☐
90845	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O12	October 2021	07	AACAP, APA, APA				☑		☐
90846	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O13	October 2021	07	AACAP, APA, APA				☑		☐
90847	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O14	October 2021	07	AACAP, APA, APA				☑		☐
90848	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O15	October 2021	07	AACAP, APA, APA				☑		☐
90849	XXX	F	Feb 2021	11	Prolonged Services - Psychotherapy	O16	October 2021	07	AACAP, APA, APA				☑		☐
908X0	ZZZ	N	Feb 2021	11	Prolonged Services - Psychotherapy	O17	October 2021	07	AACAP, APA, APA				☑		☐
92065	XXX	R	Feb 2021	35	Orthoptic Training	D1	April 2021	10	AAO, AOA	0.71	0.71		☑		☑
920XX	XXX	N	Feb 2021	35	Orthoptic Training	D2	April 2021	10	AAO, AOA				☑	PE Only	☑
92284	XXX	R	May 2021	EC-M	Dark Adaptation Examination		Editorial					Yes	☑		☐
93563	ZZZ	R	May 2021	36	Pulmonary Angiography	P1	October 2021	08	SCAI				☑		☐
93564	ZZZ	R	May 2021	36	Pulmonary Angiography	P2	October 2021	08	SCAI				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93565	ZZZ	R	May 2021	36	Pulmonary Angiography	P3	October 2021	08	SCAI				☑		☐
93566	ZZZ	R	May 2021	36	Pulmonary Angiography	P4	October 2021	08	SCAI				☑		☐
93567	ZZZ	R	May 2021	36	Pulmonary Angiography	P5	October 2021	08	SCAI				☑		☐
93568	ZZZ	R	May 2021	36	Pulmonary Angiography	P6	October 2021	08	SCAI				☑		☐
93XX0	ZZZ	N	May 2021	36	Pulmonary Angiography	P7	October 2021	08	SCAI				☑		☐
93XX1	ZZZ	N	May 2021	36	Pulmonary Angiography	P8	October 2021	08	SCAI				☑		☐
93XX2	ZZZ	N	May 2021	36	Pulmonary Angiography	P9	October 2021	08	SCAI				☑		☐
93XX3	ZZZ	N	May 2021	36	Pulmonary Angiography	P10	October 2021	08	SCAI				☑		☐
959XX	XXX	N	May 2021	27	Quantitative Pupillometry Services	Q1	October 2021	09	AAO				☑		☐
96X70	XXX	N	Feb 2021	39	Caregiver Behavior Management Training	E1	April 2021	11	AACAP, AND, APA (Psychology)	0.50	0.43		☑		☐
96X71	ZZZ	N	Feb 2021	39	Caregiver Behavior Management Training	E2	April 2021	11	AACAP, AND, APA (Psychology)	0.17	0.12		☑		☐
97150	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening		October 2021	HCPAC		0.29	0.29	Yes	☑		☐
97545	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening	R1	October 2021	HCPAC					☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
97546	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening	R2	October 2021	HCPAC					☑		☐
99217	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99218	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99219	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99220	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99221	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F1	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99222	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F2	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99223	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F3	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99224	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99225	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99226	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99231	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F4	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99232	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F5	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99233	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F6	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99234	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F7	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99235	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F8	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99236	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F9	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99238	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F10	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99239	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F11	October 2021	10	AAFP, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, IDSA, NASS, STS, SVS				☑		☐
99241	XXX	D	Feb 2021	07	Consultations		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99242	XXX	R	Feb 2021	07	Consultations	G1	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99243	XXX	R	Feb 2021	07	Consultations	G2	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99244	XXX	R	Feb 2021	07	Consultations	G3	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99245	XXX	R	Feb 2021	07	Consultations	G4	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99251	XXX	D	Feb 2021	07	Consultations		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99252	XXX	R	Feb 2021	07	Consultations	G5	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99253	XXX	R	Feb 2021	07	Consultations	G6	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99254	XXX	R	Feb 2021	07	Consultations	G7	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99255	XXX	R	Feb 2021	07	Consultations	G8	October 2021	12	AADA, AAHPM, AAN, AANS/CNS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS, ASSH, ATS, CHEST, NASS, SNMMI, STS, SVS				☑		☐
99281	XXX	R	Feb 2021	08	Emergency Department Services	H1	April 2021	12	AAP, ACEP, ANA	0.25	0.25		☑		☐
99282	XXX	R	Feb 2021	08	Emergency Department Services	H2	April 2021	12	AAP, ACEP, ANA	0.93	0.93	Yes	☑		☐
99283	XXX	R	Feb 2021	08	Emergency Department Services	H3	April 2021	12	AAP, ACEP, ANA	1.60	1.60	Yes	☑		☐
99284	XXX	R	Feb 2021	08	Emergency Department Services	H4	April 2021	12	AAP, ACEP, ANA	2.74	2.60		☑		☐

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99285	XXX	R	Feb 2021	08	Emergency Department Services	H5	April 2021	12	AAP, ACEP, ANA	4.00	4.00	Yes	☑		☐
99304	XXX	R	Feb 2021	09	Nursing Facility Services	I1	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.60	1.50		☑		☐
99305	XXX	R	Feb 2021	09	Nursing Facility Services	I2	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.50	2.50		☑		☐
99306	XXX	R	Feb 2021	09	Nursing Facility Services	I3	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	3.50	3.50		☑		☐
99307	XXX	R	Feb 2021	09	Nursing Facility Services	I4	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	0.70	0.70		☑		☐
99308	XXX	R	Feb 2021	09	Nursing Facility Services	I5	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.30	1.30		☑		☐
99309	XXX	R	Feb 2021	09	Nursing Facility Services	I6	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.92	1.92		☑		☐
99310	XXX	R	Feb 2021	09	Nursing Facility Services	I7	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.80	2.80		☑		☐
99315	XXX	F	Feb 2021	09	Nursing Facility Services	I8	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99316	XXX	F	Feb 2021	09	Nursing Facility Services	I9	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)				☑		☐
99318	XXX	D	Feb 2021	09	Nursing Facility Services		Deleted						☑		☐
99324	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99325	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99326	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99327	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99328	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99334	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99335	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99336	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99337	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99339	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99340	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99341	XXX	R	Feb 2021	10	Home and Residence Services	J1	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99342	XXX	R	Feb 2021	10	Home and Residence Services	J2	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99343	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99344	XXX	R	Feb 2021	10	Home and Residence Services	J3	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99345	XXX	R	Feb 2021	10	Home and Residence Services	J4	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99347	XXX	R	Feb 2021	10	Home and Residence Services	J5	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99348	XXX	R	Feb 2021	10	Home and Residence Services	J6	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99349	XXX	R	Feb 2021	10	Home and Residence Services	J7	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99350	XXX	R	Feb 2021	10	Home and Residence Services	J8	October 2021	13	AAHPM, AGS, ANA, APMA (99341, 99342, 99347, 99348 only)				☑		☐
99354	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient Contact		Deleted						☑		☐
99355	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient Contact		Deleted						☑		☐
99356	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient Contact		Deleted						☑		☐
99357	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient Contact		Deleted						☑		☐
99358	XXX	F	Feb 2021	11	Prolonged Services - with Direct Patient Contact	K1	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS, SVS				☑		☐
99359	ZZZ	F	Feb 2021	11	Prolonged Services - with Direct Patient Contact	K2	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS, SVS				☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
993X0	ZZZ	N	Feb 2021	11	Prolonged Services - On the Date of an E/M	K6	October 2021	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS, SVS				☑		☐
99415	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE Only)	K3	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS				☑	PE Only	☐
99416	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE Only)	K4	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS				☑	PE Only	☐
99417	ZZZ	R	Feb 2021	11	Prolonged Services - On the Date of an E/M	K5	October 2021	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS, SVS				☑		☐
99446	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial					Yes	☑		☐
99447	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial					Yes	☑		☐
99448	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial					Yes	☑		☐
99449	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial					Yes	☑		☐
99451	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial					Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99483	XXX	R	Feb 2021	11	Cognitive Assessment and Care Plan Services	L1	April 2021	16	AAN, ACP, AGS	3.80	3.50		☑		☐

CPT 2022 RUC and HCPAC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
002XM	XXX	N	May 2021	23	Admin MAAA-Renal Allograft Rejection Risk		CLFS						☐		☐
0101T	XXX	R	May 2021	43	Category III – Extracorporeal Shock Wave Therapy Code Revisions		Cat III						☐		☐
0102T	XXX	R	May 2021	43	Category III – Extracorporeal Shock Wave Therapy Code Revisions		Cat III						☐		☐
0191T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
01935	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01936	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01XX2	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H1	January 2021	4	ASA	4.00	4.00		☑		☐
01XX3	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H2	January 2021	4	ASA	4.00	4.00		☑		☐
01XX4	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H3	January 2021	4	ASA	5.00	4.00		☑		☐
01XX5	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H4	January 2021	4	ASA	4.00	4.00		☑		☐
01XX6	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H5	January 2021	4	ASA	7.00	6.00		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
01XX7	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H6	January 2021	4	ASA	7.00	6.00		☑		☐
0290T	XXX	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0355T	XXX	D	Oct. 2020	58	Colon Capsule Endoscopy		Cat III						☐		☐
0356T	XXX	D	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion		Cat III						☐		☐
0376T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
0423T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0451T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0452T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0453T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0454T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0455T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0456T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0457T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0458T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0459T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0460T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0461T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0462T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐

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0463T	XXX	D	May 2021	56	Category III Sundown		Cat III						☐		☐
0466T	XXX	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0467T	XXX	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0468T	XXX	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
050XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
0512T	XXX	R	May 2021	43	Category III – Extracorporeal Shock Wave Therapy Code Revisions		Cat III						☐		☐
0513T	XXX	R	May 2021	43	Category III – Extracorporeal Shock Wave Therapy Code Revisions		Cat III						☐		☐
051XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
052XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
053XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
0548T	XXX	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐

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0549T	XXX	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
054XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
0550T	XXX	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0551T	XXX	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
055XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
056XT	XXX	N	Feb. 2021	41	Cat III Histotripsy		Cat III						☐		☐
057XT	XXX	N	Feb. 2021	45	Cat III Therapeutic Ultrafiltration		Cat III						☐		☐
058XT	XXX	N	Feb. 2021	42	Cat III Amblyopia Training Services		Cat III						☐		☐
059XT	XXX	N	Feb. 2021	42	Cat III Amblyopia Training Services		Cat III						☐		☐
060XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
061XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
062XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐

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063XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
064XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
065XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
06X0T	XXX	N	Feb. 2021	19	Cat III Dual Energy Tissue Remodeling		Cat III						☐		☐
06X7T	XXX	N	May 2021	41	Category III – Multiparametric MR of Multiple Organs		Cat III						☐		☐
0X12T	XXX	N	Oct. 2020	37	Cat III Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
0X31T	XXX	N	May 2021	41	Category III – Multiparametric MR of Multiple Organs		Cat III						☐		☐
0X32T	XXX	N	May 2021	41	Category III – Multiparametric MR of Multiple Organs		Cat III						☐		☐
0X33T	XXX	N	Feb. 2021	43	Cat III Quantitative Ultrasound Tissue Characterization (Non-Elastographic)		Cat III						☐		☐
0X34T	XXX	N	Feb. 2021	43	Cat III Quantitative Ultrasound Tissue Characterization (Non-Elastographic)		Cat III						☐		☐
0X36T	XXX	N	Feb. 2021	44	Cat III Automated Analysis of an Existing Computed Tomography Study		Cat III						☐		☐

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0X37T	XXX	N	May 2021	41	Category III – Multiparametric MR of Multiple Organs		Cat III						☐		☐
0X45T	XXX	N	Feb. 2021	20	Cat III Thyroid Nodule Laser Ablation		Cat III						☐		☐
0X47T	XXX	N	May 2021	47/48	Category III – Remote Cognitive Behavioral Therapy Services		Cat III						☐		☐
0X57T	XXX	N	May 2021	49	Category III – Remote Amblyopia Treatment		Cat III						☐		☐
0X58T	XXX	N	May 2021	49	Category III – Remote Amblyopia Treatment		Cat III						☐		☐
0X59T	XXX	N	May 2021	49	Category III – Remote Amblyopia Treatment		Cat III						☐		☐
0X60T	XXX	N	May 2021	37	Category III – Markerless 3D Kinetic Motion Analysis		Cat III						☐		☐
0X65T	XXX	N	May 2021	46	Category III – Fluorescent Molecular Imaging of Skin		Cat III						☐		☐
0X66T	XXX	N	May 2021	46	Category III – Fluorescent Molecular Imaging of Skin		Cat III						☐		☐
0X68T	XXX	N	May 2021	52	Category III – Immunotherapeutic Cancer Vaccine and Injection		Cat III						☐		☐
0X69T	XXX	N	May 2021	52	Category III – Immunotherapeutic Cancer Vaccine and Injection		Cat III						☐		☐
0X70T	XXX	N	May 2021	53	Category III – Noninvasive Arterial Plaque Quantification		Cat III						☐		☐

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0X71T	XXX	N	May 2021	53	Category III – Noninvasive Arterial Plaque Quantification		Cat III						☐		☐
0X72T	XXX	N	May 2021	53	Category III – Noninvasive Arterial Plaque Quantification		Cat III						☐		☐
0X73T	XXX	N	May 2021	53	Category III – Noninvasive Arterial Plaque Quantification		Cat III						☐		☐
0X74T	XXX	N	May 2021	38	Category III – 3D Volumetric Imaging of Breast Specimen		Cat III						☐		☐
0X75T	XXX	N	May 2021	39	Category III – Body Surface Mapping for Cardiac Lead Optimization		Cat III						☐		☐
0X76T	XXX	N	May 2021	39	Category III – Body Surface Mapping for Cardiac Lead Optimization		Cat III						☐		☐
0X78T	XXX	N	May 2021	44	Category III – Posterior Chamber Eye Injection		Cat III						☐		☐
0X79T	XXX	N	May 2021	51	Category III – Injection Bone Substitute into Subchondral Defect		Cat III						☐		☐
0X81T	XXX	N	May 2021	47/48	Category III – Remote Cognitive Behavioral Therapy Services		Cat III						☐		☐
11981	000	R	May 2021	35	Bioresorbable Controlled-Release Hormone Implantation		Editorial			1.41	1.41	Yes	☑		☐
12001	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			0.84	0.84	Yes	☑		☐

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12002	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.14	1.14	Yes	☑		☐
12004	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.44	1.44	Yes	☑		☐
12005	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.97	1.97	Yes	☑		☐
12006	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.39	2.39	Yes	☑		☐
12007	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.90	2.90	Yes	☑		☐
12011	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.07	1.07	Yes	☑		☐
12013	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.22	1.22	Yes	☑		☐
12014	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.57	1.57	Yes	☑		☐
12015	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.98	1.98	Yes	☑		☐
12016	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.68	2.68	Yes	☑		☐
12017	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.18	3.18	Yes	☑		☐
12018	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.61	3.61	Yes	☑		☐
21310	000	D	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture		January 2021						☑		☐
21315	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I1	January 2021	5	AAOHNS, ASPS	2.00	2.00		☑		☐
21320	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I2	January 2021	5	AAOHNS, ASPS	2.33	2.33		☑		☐

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22600	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	4		17.40	17.40	Yes	☑		☐
22610	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	4		17.28	17.28	Yes	☑		☐
22612	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	4		23.53	23.53	Yes	☑		☐
22614	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	4		6.43	6.43	Yes	☑		☐
22630	090	F	Oct. 2020	20	Arthrodesis Decompression	J1	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	22.09	22.09	Yes	☑		☐
22632	ZZZ	F	Oct. 2020	20	Arthrodesis Decompression	J2	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	5.22	5.22	Yes	☑		☐
22633	090	R	Oct. 2020	20	Arthrodesis Decompression	J3	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	26.80	26.80		☑		☐
22634	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression	J4	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	7.96	7.96		☑		☐
33361	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K1	January 2021	7	ACC, SCAI	22.47	22.47	Yes	☑		☐
33362	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K2	January 2021	7	ACC, SCAI	24.54	24.54	Yes	☑		☐
33363	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K3	January 2021	7	ACC, SCAI	25.47	25.47	Yes	☑		☐
33364	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K4	January 2021	7	ACC, SCAI	25.97	25.97	Yes	☑		☐
33365	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K5	January 2021	7	ACC, SCAI	26.59	26.59	Yes	☑		☐
33366	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K6	January 2021	7	ACC, SCAI	29.35	29.35	Yes	☑		☐
33367	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K7	January 2021	7	ACC, SCAI	11.88	11.88	Yes	☑		☐

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33368	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K8	January 2021	7	ACC, SCAI	14.39	14.39	Yes	☑		☐
33369	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K9	January 2021	7	ACC, SCAI	19.00	19.00	Yes	☑		☐
33470	090	D	May 2021	57	Code Set Maintenance		Deleted						☑		☐
33722	090	D	May 2021	57	Code Set Maintenance		Deleted						☑		☐
33746	ZZZ	R	Feb. 2021	EC-D	Cardiac Catheterization for Congenital Defects		Editorial			8.00	8.00	Yes	☑		☐
338X0	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L3	January 2021	8	ACC, SCAI, SIR	17.00	14.00		☑		☐
338X1	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L1	January 2021	8	ACC, SCAI, SIR	23.30	21.70		☑		☐
338X2	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L2	January 2021	8	ACC, SCAI, SIR	20.00	17.97		☑		☐
33XX3	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A1	October 2020	5	AATS, STS	18.50	18.50		☑		☑
33XX4	ZZZ	N	May 2020	12	Exclusion of Left Atrial Appendage	A2	October 2020	5	AATS, STS	3.00	2.50		☑		☑
33XX5	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A3	October 2020	5	AATS, STS	15.73	14.31		☑		☑
33XXX	ZZZ	N	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K10	January 2021	7	ACC, SCAI	3.43	2.50		☑		☑
35600	XXX	R	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B2	January 2021	9	AAPA, AATS, ANA, STS	4.00	4.00		☑		☐
35XX0	XXX	N	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B1	January 2021	9	AAPA, AATS, ANA, STS	3.75	3.75		☑		☑

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42XXX	000	N	Oct. 2020	27	Drug Induced Sleep Endoscopy (DISE)	M1	April 2021	5	AAOHNS	1.95	1.95		☑	New recommendation after Feb. 2021 interim recommendations	☐
434XX	090	N	May 2020	14	Per-Oral Endoscopic Myotomy (POEM)	C1	October 2020	7	AATS, ACG, AGA, ASGE, SAGES, STS ACG AGA ASGE SAGES STS	15.50	15.50		☑		☑
43850	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
43855	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
53XX1	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N1	January 2021	11	AUA				☑	Contractor Price	☑
53XX2	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N2	January 2021	11	AUA				☑	Contractor Price	☑
53XX3	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N3	January 2021	11	AUA				☑	Contractor Price	☑
53XX4	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N4	January 2021	11	AUA				☑	Contractor Price	☑
54340	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			9.71	9.71	Yes	☑		☐
54344	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			17.06	17.06	Yes	☑		☐
54348	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			18.32	18.32	Yes	☑		☐
54352	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			26.13	26.13	Yes	☑		☐
59135	090	D	May 2021	57	Code Set Maintenance		Deleted						☑		☐
617X1	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O1	January 2021	12	AANS, CNS	20.00	20.00		☑		☑

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617X2	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O2	January 2021	12	AANS, CNS	24.00	24.00		☑		☑
630X1	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J6	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	5.00	5.00		☑	New recommendations after Feb. 2021 interim recommendations	☐
630XX	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J5	April 2021	4	AANS, AAOS, CNS, ISASS, NASS	5.70	5.70		☑	New recommendations after Feb. 2021 interim recommendations	☐
63194	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
63195	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
63196	090	D	May 2021	57	Code Set Maintenance		Deleted						☑		☐
63199	090	D	May 2021	57	Code Set Maintenance		Deleted						☑		☐
64568	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.00	9.00	Yes	☑		☐
64569	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			11.00	11.00	Yes	☑		☐
64570	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.10	9.10	Yes	☑		☐
64575	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.42	4.42	Yes	☑		☐
64580	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.19	4.19	Yes	☑		☐
64581	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			12.20	12.20	Yes	☑		☐
645X1	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P1	January 2021	13	AAOHNS	16.00	16.00		☑		☐
645X2	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P2	January 2021	13	AAOHNS	17.04	16.50		☑		☐
645X3	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P3	January 2021	13	AAOHNS	14.00	14.00		☑		☐

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646X0	010	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q1	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS	9.75	8.25		☑		☑
646X1	ZZZ	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q2	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS	4.87	4.87		☑		☑
66174	090	R	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R1	January 2021	15	AAO	8.60	8.53		☑		☐
66175	090	F	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R2	January 2021	15	AAO	10.25	10.25		☑		☐
66982	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S1	January 2021	16	AAO, ASCRS	10.25	10.25	Yes	☑		☐
66984	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S4	January 2021	16	AAO, ASCRS	7.35	7.35	Yes	☑		☐
66987	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S3	January 2021	16	AAO, ASCRS	13.15	13.15	Yes	☑		☐
66988	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S5	January 2021	16	AAO, ASCRS	10.25	10.25	Yes	☑		☐
669X1	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S2	January 2021	16	AAO, ASCRS	12.13	12.13		☑		☑
669X2	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S6	January 2021	16	AAO, ASCRS	11.05	9.23		☑		☑
67141	010	R	May 2020	16	Retinal Detachment Prophylaxis	D1	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
67145	010	R	May 2020	16	Retinal Detachment Prophylaxis	D2	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
68XXX	000	N	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion	T1	January 2021	17	AAO, ASCRS	0.49	0.49		☑		☑

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69714	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U1	January 2021	18	AAOHNS	11.00	8.69		☑	Interim - resurvey for Oct. 2021	☐
69715	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐
69717	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U3	January 2021	18	AAOHNS	11.48	8.80		☑	Interim - resurvey for Oct. 2021	☐
69718	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐
69X50	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U2	January 2021	18	AAOHNS	12.00	9.77		☑	Interim - resurvey for Oct. 2021	☐
69X51	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U4	January 2021	18	AAOHNS	12.00	9.77		☑	Interim - resurvey for Oct. 2021	☐
69X52	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U5	January 2021	18	AAOHNS	10.00	5.93		☑	Interim - resurvey for Oct. 2021	☐
69X53	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U6	January 2021	18	AAOHNS	10.98	7.13		☑	Interim - resurvey for Oct. 2021	☐
72275	XXX	D	Oct. 2020	40	Epidurography		Deleted						☑		☐
75573	XXX	R	May 2020	18	CT of the Heart		Editorial			2.55	2.55	Yes	☑		☐
76101	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
76102	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
77X01	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V1	January 2021	19	ACR	0.20	0.20		☑		☑
77X02	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V2	January 2021	19	ACR	0.00	0.00		☑	PE Only	☑
77X03	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V3	January 2021	19	ACR	0.00	0.00		☑	PE Only	☑
77X04	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V4	January 2021	19	ACR	0.20	0.20		☑		☑
801XX	XXX	N	May 2021	16	Hydroxychloroquine Therapeutic Drug		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
80500	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐
80502	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐
80XX0	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W1	January 2021	20	CAP	0.50	0.50		☑		☐
80XX1	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W2	January 2021	20	CAP	0.91	0.91		☑		☐
80XX2	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W3	January 2021	20	CAP	1.80	1.80		☑		☐
80XX3	ZZZ	N	Oct. 2020	50	Pathology Clinical Consult	W4	January 2021	20	CAP	0.80	0.80		☑		☐
81194	XXX	R	May 2021	EC-A	NTRK Translocation Analysis		CLFS						☐		☐
81228	XXX	R	May 2021	60	Cytogenomic Constitutional Analysis Low Pass Sequencing		CLFS						☐		☐
81229	XXX	R	May 2021	60	Cytogenomic Constitutional Analysis Low Pass Sequencing		CLFS						☐		☐
812X0	XXX	N	May 2021	60	Cytogenomic Constitutional Analysis Low Pass Sequencing		CLFS						☐		☐
815X0	XXX	N	Oct. 2020	45	MAAA Allograft Rejection Risk		CLFS						☐		☐
815X1	XXX	N	Oct. 2020	46	MAAA Breast Cancer Metastasis RNA Sequencing		CLFS						☐		☐
82656	XXX	R	May 2021	17	Pancreatic Elastase Quantitative Test		CLFS						☐		☐
826X0	XXX	N	May 2021	17	Pancreatic Elastase Quantitative Test		CLFS						☐		☐
8352X	XXX	N	Feb. 2021	23	Light Chains (Kappa and Lambda) Testing		CLFS						☐		☐
835X1	XXX	N	Feb. 2021	22	Interleukin 6 Immunoassay		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
860X1	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
860X2	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
860XX	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
860XX	XXX	N	May 2021	21	Antineutrophil Cytoplasmic Antibodies (ANCA)		CLFS						☐		☐
862X0	XXX	N	Feb. 2021	25	Endomysial Antibody (EMA) Ig Test-Celiac Dx		CLFS						☐		☐
862X1	XXX	N	Feb. 2021	27	Tissue Transglutaminase (TTG) Ig Test-Celiac Dx		CLFS						☐		☐
862XX	XXX	N	Feb. 2021	26	Deamidated Gliadin Peptide (DGP) Ig Test-Celiac Dx		CLFS						☐		☐
863X1	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
863X4	XXX	N	May 2021	18	Mitochondrial Antibody		CLFS						☐		☐
863XX	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
865X0	XXX	N	May 2021	19	Voltage-Gated Calcium Channel Antibody		CLFS						☐		☐
86X01	XXX	N	May 2021	21	Antineutrophil Cytoplasmic Antibodies (ANCA)		CLFS						☐		☐
86XX0	XXX	N	May 2021	20	Actin Smooth Muscle Antibody (ASMA)		CLFS						☐		☐
8715X	XXX	N	May 2021	22	Blood Culture Identification PCR Multiplex Panel		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
9074X	XXX	N	Feb. 2021	28	Hepatitis B 3-Antigen Vaccine		Vaccine						☐		☐
90785	ZZZ	R	Oct. 2020	55	Psychiatric Interactive Complexity Instructions		Editorial			0.33	0.33	Yes	☑		☐
91110	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X1	January 2021	21	ACG, AGA, ASGE	2.24	2.24		☑		☐
91111	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X2	January 2021	21	ACG, AGA, ASGE	1.00	1.00	Yes	☑		☐
9111X	XXX	N	Oct. 2020	58	Colon Capsule Endoscopy	X3	January 2021	21	ACG, AGA, ASGE	2.41	2.41		☑		☑
92065	XXX	R	May 2020	37	Orthoptic Training	E1	October 2020	9	AAO, AOA				☑	Refer to CPT	☐
92559	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92560	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92561	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92564	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92626	XXX	R	May 2020	38	Evaluation of Auditory Function		Editorial			1.40	1.40	Yes	☑		☐
92627	ZZZ	R	May 2020	38	Evaluation of Auditory Function		Editorial			0.33	0.33	Yes	☑		☐
92651	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.00	1.00	Yes	☑		☐
92652	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.50	1.50	Yes	☑		☐
92653	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.05	1.05	Yes	☑		☐
933X0	ZZZ	N	May 2020	39	3D Imaging of Cardiac Structures	G1	October 2020	11	ACC, ASE	0.50	0.50		☑		☑
93530	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93531	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93532	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93533	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93561	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93562	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93613	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y1	April 2021	07	ACC, HRS	5.23	5.23	Yes	☑	Affirm Feb. 2017 RUC Recommendation	☐
93621	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y2	April 2021	07	ACC, HRS	1.75	1.75		☑	Affirm Oct. 2020 RUC recommendation	☐
93653	000	R	Oct. 2020	61	Cardiac Ablation	Y3	April 2021	07	ACC, HRS	15.00	15.00		☑	New recommendations after Feb. 2021 interim recommendations	☐
93654	000	R	Oct. 2020	61	Cardiac Ablation	Y4	April 2021	07	ACC, HRS	18.10	18.10		☑	New recommendations after Feb. 2021 interim recommendations	☐
93655	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y5	April 2021	07	ACC, HRS	7.00	7.00		☑	New recommendations after Feb. 2021 interim recommendations	☐
93656	000	R	Oct. 2020	61	Cardiac Ablation	Y6	April 2021	07	ACC, HRS	17.00	17.00		☑	New recommendations after Feb. 2021 interim recommendations	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93657	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y7	April 2021	07	ACC, HRS	7.00	7.00		☑	New recommendations after Feb. 2021 interim recommendations	☐
93662	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y8	April 2021	07	ACC, HRS	2.53	2.53		☑	Affirm May 2019 RUC recommendation	☐
93X1X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F1	October 2020	10	AAP, ACC, SCAI	3.99	3.99		☑		☑
93X2X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F2	October 2020	10	AAP, ACC, SCAI	6.10	6.10		☑		☑
93X3X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F3	October 2020	10	AAP, ACC, SCAI	6.00	6.00		☑		☑
93X4X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F4	October 2020	10	AAP, ACC, SCAI	7.91	7.91		☑		☑
93X5X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F5	October 2020	10	AAP, ACC, SCAI	11.74	9.99		☑		☑
93X6X	ZZZ	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F6	October 2020	10	AAP, ACC, SCAI	2.00	1.75		☑		☑
946X1	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z1	January 2021	23	ATS, CHEST	0.55	0.55		☑		☑
946X2	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z2	January 2021	23	ATS, CHEST	0.69	0.69		☑		☑
95943	XXX	D	Oct. 2020	65	Autonomic Function Testing		Deleted						☑		☐
989X1	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA1	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑
989X2	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA2	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
989X3	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA3	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑
989X4	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA4	January 2021	24	AAP, AAPM&R, ANA, APTA	0.62	0.62		☑		☑
989X5	ZZZ	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA5	January 2021	24	AAP, AAPM&R, ANA, APTA	0.61	0.61		☑		☑
99211	XXX	R	Feb. 2021	06	Office Visit 99211 Editorial Revision		Editorial			0.18	0.18	Yes	☑		☐
99354	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		2.33	2.33	Yes	☑		☐
99355	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.77	1.77	Yes	☑		☐
99356	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐
99357	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐
99358	XXX	R	May 2020	EC-G	Prolonged Services	U1	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA	2.10	2.10	Yes	☑	Refer to CPT, 2023 cycle	☐
99359	ZZZ	R	May 2020	EC-G	Prolonged Services	U2	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA	1.00	1.00	Yes	☑	Refer to CPT, 2023 cycle	☐
99366	XXX	R	May 2021	EC-B	CCM, Medical Team Conferences		Editorial			0.82	0.82	Yes	☑		☐
99439	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB6	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	0.70	0.70		☑		☑
99483	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			3.80	3.80	Yes	☑		☐
99484	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			0.61	0.61	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99487	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB9	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.81	1.81		☑		☑
99489	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB10	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99490	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB5	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99491	XXX	R	May 2021	EC-B	CCM, Medical Team Conferences		Editorial			1.45	1.45	Yes	☑		☐
99491	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB7	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.50	1.50		☑		☑
99492	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			1.88	1.88	Yes	☑		☐
99493	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			2.05	2.05	Yes	☑		☐
99X21	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB8	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X22	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB1	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.45	1.45		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99X23	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB2	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X24	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB3	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X25	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB4	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	0.62	0.71		☑		☑
99XXX	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		0.61	0.61	Yes	☑		☐
G0424	XXX	D	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services		Deleted						☑	RUC recommends deletion	☐
G2064	XXX	D	Oct. 2020	13	Principal Care Management and Chronic Care Management		Deleted						☑	RUC recommends deletion	☐
G2065	XXX	D	Oct. 2020	13	Principal Care Management and Chronic Care Management		Deleted						☑	RUC recommends deletion	☐

RUC Recommendations for CMS Requests & Relativity Assessment Identified Code - April 2021

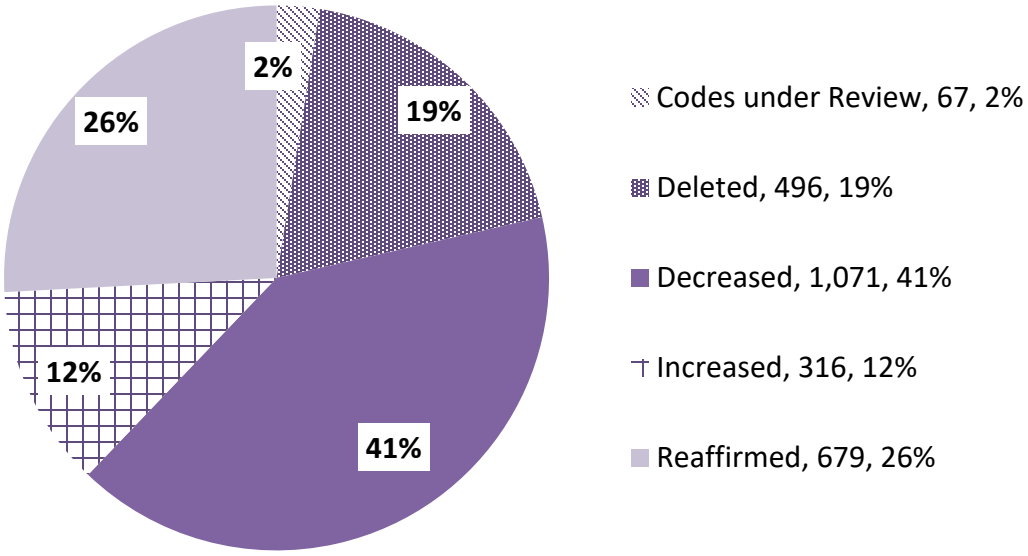
CPT Code	Long Descriptor	Issue	Tab	RUC Recommendation	CMS Request - Final Rule for 2021	CPT Assistant Analysis	Harvard Valued - Medicare Util Over 30,000	New Technology/ New Service	Site of Service Anomaly
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Insertion of Spinal Stability Distractive Device	17	7.03				X	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Insertion of Spinal Stability Distractive Device	17	2.34				X	
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Knee Arthroplasty	18	17.13					X
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Knee Arthroplasty	18	19.60					X
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	Immunization Administration	19	0.24	X				
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)	Immunization Administration	19	0.18	X				
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	Immunization Administration	19	0.17	X				
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	Immunization Administration	19	0.15	X				
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	Immunization Administration	19	0.17	X				
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	Immunization Administration	19	0.15	X				
G0008	Administration of influenza virus vaccine	Immunization Administration	19	0.17	X				
G0009	Administration of pneumococcal vaccine	Immunization Administration	19	0.17	X				
G0010	Administration of hepatitis b vaccine	Immunization Administration	19	0.17	X				
92284	Dark adaptation examination with interpretation and report	Dark Adaption Eye Exam	20	0.14			X		
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	Anterior Segment Imaging	21	0.40		X	X		

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the AMA/Specialty Society RVS Update Committee (RUC) established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and the Centers for Medicare and Medicaid Services (CMS) have identified over 2,600 services through over 20 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining 2,629 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,567 services, redistributing $5 billion annually. Here are the outcomes for the committee's review of 2,629 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 730 services. In September 2010, the re-review cycle began and since then the RUC has recommended 52 services to be re-examined. The remaining services are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 256 services every January after three years of Medicare claims data is available for each service.

Methodology Improvements
The RUC implemented process improvements to methodology following its October 2013 meeting. The process improvements are designed to strengthen the RUC's primary mission of providing the final RVS update recommendations to the Centers for Medicare and Medicaid Services.

In the area of methodology, the RUC is continuously improving its processes to ensure that it is best utilizing reliable, extant data. At its most recent meeting, the RUC increased the minimum number of respondents required for each survey of commonly performed codes:

- For services performed 1 million or more times per year in the Medicare population, at least 75 physicians must complete the survey.
- For services performed from 100,000 to 999,999 times annually, at least 50 physicians will be required.

Further strengthening its methodology, the RUC also announced that specialty societies will move to a centralized online survey process, which will be coordinated by the AMA and will utilize external expertise to ensure survey and reporting improvements.

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

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

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained three codes and removed two codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT® Editorial Panel deleted 14 codes. The RUC completed review of services under this initial screen.

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

The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise. In 2015, the RUC identified three services in which the Medicare data from 2011-2013 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. These services were referred to CPT and recommendations were submitted to CMS for the 2018 Medicare Physician Payment Schedule.

In 2016, the RUC identified one site of service anomaly CPT code and submitted the recommendation to CMS for the 2019 Medicare Physician Payment Schedule. In 2017, the RUC identified one site of service anomaly CPT code which was revised at the CPT Editorial Panel and the RUC submitted recommendations for the 2020 Medicare Physician Payment Schedule.

In 2018, the RUC also performed a site-of-service anomaly screen based on the review of three years of data (2015, 2016 and 2017e) for services with utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. One service was identified via this screen and another identified for the outpatient site of service anomaly screen. The RUC submitted this recommendation for the 2021 Medicare Physician Payment Schedule.

In 2019, the RUC lowered the threshold for site-of-service anomalies based on the review of three years of data (2016, 2017 and 2018e) for services with utilization over 5,000 in the outpatient setting more than 50% of the time but includes inpatient hospital Evaluation and Management services within the global period. The RUC identified nine services, expanding to 38 services to include the family of services. The RUC referred two codes to the CPT Editorial Panel for revision, CPT deleted 13 services and the RUC submitted 23 recommendations for the 2021-2023 Medicare Physician Payment Schedule.

In 2020, the RUC identified one code with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The RUC submitted this recommendation for the 2021 Medicare Physician Payment Schedule.

High Volume Growth

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 16 services to include the family of services, totaling 97 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide rationales for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 15 services from the screen as the volume growth did not impact the resources required to provide these services. The CPT® Editorial Panel deleted 34 codes. The RUC submitted 44 recommendations to CMS for services for the 2012-2017 Medicare Physician Payment Schedules and four recommendations for the CPT 2020 Medicare Physician Payment Schedule. The RUC completed review of services under this first iteration of the high growth screen.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 62 services to include the appropriate family of services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended review of one service after an additional utilization data is collected. The CPT® Editorial Panel deleted ten codes and the RUC submitted recommendations for 48 services for the 2015-2019 and 2023 Medicare Physician Payment Schedules.

In October 2015, the RUC ran this screen again for services based on Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 19 services and expanded to 31 services to include the appropriate family of services. The RUC recommended removing one service from the screen as the volume growth did not impact the

resources required to provide these services. The RUC will review three services after an additional utilization data is collected. The CPT Editorial Panel deleted 12 codes and the RUC submitted recommendations for 15 services for the 2017-2020 Medicare Physician Payment Schedules.

In October 2016, the RUC ran this screen for its fourth iteration and the query resulted in the identification of 12 services, which was expanded to 53 services. The RUC recommended removing two services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted five services. The RUC submitted recommendations for 46 services for the 2019-2022 Medicare Physician Payment Schedules. The RUC completed review of services under this fourth iteration of the high volume growth screen.

In October 2018, the RUC ran this query for its fifth iteration for services with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. Eleven (11) codes were identified. The RUC recommended removing two services from the screen as the volume growth was appropriate. The CPT Editorial Panel deleted one code. The RUC referred one code to the CPT Editorial Panel for revision and submitted recommendations for seven services for the 2020-2021 Medicare Physician Payment Schedule.

In October 2019, the RUC completed its sixth iteration of this screen for services with 2018e Medicare utilization of over 10,000 that have increased by at least 100% from 2013 through 2018. The RUC identified 13 services. The RUC removed three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review one code after additional utilization data is available. The RUC submitted recommendations for seven services for the 2021 Medicare Physician Payment Schedule and for three services for the 2023 Medicare Physician Payment Schedule.

In October 2020, the RUC completed its seventh iteration of this screen for services with 2019e Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019. The RUC identified six services. The RUC removed four services as the growth was appropriate, referred one code to CPT for revision and submitted a recommendation for one service for the 2023 Medicare Physician Payment Schedule.

CMS Fastest Growing

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

The RUC recommended removing 27 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT® Editorial Panel deleted 43 codes. The RUC submitted 41 recommendations to CMS for the 2012-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

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

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

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and the RUC recommended that one be removed from the screen since the specialty societies currently performing this service indicated that the service is appropriate and recommended that the other code be referred to CPT® to be revised. The RUC completed review of services under this screen.

In October 2019, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified, one was deleted by CPT Editorial Panel and other was referred to develop a CPT Assistant article for education. The RUC completed review of services under this screen

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

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

Utilization over 30,000
In April 2011, the RUC continued to identify Harvard valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT® Editorial Panel deleted 12 codes. The RUC submitted recommendations for 53 services for the 2013-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2015, the RUC reran this screen on Harvard valued services with 2014e Medicare utilization over 30,000. Seven services were identified and expanded to nine codes to include the family of services. The CPT Editorial Panel deleted two codes. The RUC submitted recommendations for 7 services for the 2018-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2018, the RUC reran this screen on Harvard valued services with 2017e Medicare utilization over 30,000. One service was identified. The RUC submitted this recommendation for the 2021 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

In October 2019, the RUC reran this screen on Harvard valued services with 2018e Medicare utilization over 30,000. Three services were identified, which was expanded to five to include the family of services. The RUC submitted recommendations for these five services for the 2022-2023 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2020, the RUC ran this service on Harvard valued services with 2019e Medicare utilization over 30,000 and one service was identified. The RUC submitted a recommendation for this service for the 2023 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Medicare Allowed Charges >$10 million
In June 2012, CMS identified 16 services that were Harvard valued with annual allowed charges (2011 data) > $10 million. The RUC expanded this screen to 33 services to include the proper family of services. The RUC removed two services from review as the allowed charges are approximately $1 million and did not meet the screen criteria. The CPT® Editorial Panel deleted one service. The RUC submitted recommendations for 30 services for the 2013-2017 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS/Other
Utilization over 500,000
In April 2011, the RUC identified 410 codes with a source of "CMS/Other." CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The CPT® Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will review one code after additional data are available.

Utilization over 250,000
In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services and was expanded to 52 services to include the family of services. The CPT Editorial Panel deleted 11 codes identified under this screen. The RUC removed nine services and submitted 32 recommendations to CMS for the 2015-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000
In October 2016, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 100,000 or more, which resulted in 27 services and was expanded to 41 services to include the family of services. The RUC referred two codes to CPT for deletion and submitted recommendations for 39 services for the 2019 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Utilization over 30,000
In October 2017, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 30,000 or more, which resulted in 34 services and was expanded to 55 services to include the family of services. The CPT Editorial Panel deleted 10 codes. The submitted recommendations for 45 services for the 2019-2020 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2018, the RUC reran this screen for CMS/Other source codes with 2017e Medicare utilization over 30,000, which resulted in seven services and expanded to 15 services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 14 services for the 2020-21 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 20,000
In October 2019, the RUC lowered the threshold for this screen of CMS/Other source codes with 2018e Medicare utilization over 20,000, which resulted in nine services and expanded to 15 to include the family of services. The RUC removed one code from the screen and referred one to the CPT Editorial Panel for revision. The CPT Editorial Panel deleted five codes. The RUC submitted recommendations for seven services for the 2021-2022 Medicare Physician Payment Schedules. The RUC will review one service after additional utilization data is available.

In October 2020, the RUC ran a second iteration of this screen of CMS/Other source codes with 2019e Medicare Utilization over 20,000, which resulted in 11 services. Three services were removed from this screen, one was referred to the CPT Editorial Panel for revision and seven will be reviewed after additional utilization data is available.

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

Reported 75% or More Together
In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar "groups" to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the

CPT® Editorial Panel deleted 35 individual component codes and replaced the component coding with 126 new and/or revised codes that described the bundles of services. The RUC will review one service after additional utilization data is available.

In August 2011, the Joint CPT®/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair groups and recommended code bundling for 64 individual codes. In October 2012, the CPT® Editorial Panel started the review of code bundling solutions. Of the 153 total codes under review, the CPT® Editorial Panel deleted 50 services. The RUC has submitted 103 code recommendations for the 2014-2019 Medicare Physician Payment Schedules. The RUC completed review of all services under this screen.

In January and April 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its fourth cycle analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 8 code pair groups and recommended code bundling for 18 individual codes. In October 2015, the CPT Editorial Panel started review of the code bundling solutions. Of the 75 total codes under review, the CPT Editorial Panel deleted 26 services. The RUC submitted 47 code recommendations for the 2017-2019 Medicare Physician Payment Schedules and will review the two services after additional utilization data is available.

In October 2017 the Relativity Assessment Workgroup performed the fifth cycle analysis of code pairs reported together with 75% or greater frequency. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups or 8 codes were identified. The Relativity Assessment Workgroup determined two groups totaling four codes require code bundling solutions. Of the 12 total codes under review, the CPT Editorial Panel deleted one service. The RUC submitted 11 code recommendations for the 2020 and 2021 Medicare Physician Payment Schedules. The RUC completed review of all services under this screen.

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

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

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

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 182 services to include additional codes as part of a family (over 100 of these codes are part of the review of GI endoscopy codes). The CPT® Editorial Panel deleted 25 codes. The RUC submitted recommendations for 157 codes for the 2012-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS High Expenditure Procedural Codes
In the Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high Medicare Physician Payment Schedule expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 145 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 20 codes. The RUC submitted 125 recommendations to CMS for the 2013-2019 Medicare Physician Payment Schedules. The RUC completed review of services under the first iteration of this screen.

In the Final Rule for 2016, CMS requested that the RUC review a list of 103 high Medicare Physician Payment Schedule high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

The RUC expanded the list of services to 238 services to include additional codes as part of the family. The CPT Editorial Panel deleted 30 codes. The RUC submitted 208 recommendations to CMS for the 2017-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Services with Stand-Alone PE Procedure Time
In June 2012, CMS proposed adjustments to services with stand-alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT® codes that have annual Medicare allowed charges of $100,000 or more, include direct equipment inputs that amount to $100 or more, and have PE procedure times greater than five minutes for review. The RUC reviewed 27 services identified through this screen and expanded to 29 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 11 codes. The RUC submitted 18 recommendations for the 2014-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Pre-Time Analysis
In January 2014, the RUC reviewed codes that were RUC reviewed prior to April 2008, with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package and was expanded to 24 to include additional codes as part of the family. The RUC reviewed these services and referred three services to the CPT® Editorial Panel for revision. The CPT Editorial Panel deleted one service and will review three services for CPT 2018. The RUC reviewed 18 services and noted that they were all originally valued by magnitude estimation and therefore readjustments in pre-service time categories did not alter the work values. Additionally, crosswalk references for each service were presented validating the pre-time adjustments.

The RUC noted that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services. The RUC submitted 20 recommendations for the 2016 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Post-Operative Visits

010-Day Global Codes

In January 2014, the RUC reviewed all 477, 010-day global codes to determine any outliers. Many 010-day global period services only include one post-operative office visit. The Relativity Assessment Workgroup pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC reviewed the 19 services, which was expanded to 21 services for additional codes in the family of services, identified via this screen. The RUC referred two codes to the CPT Editorial Panel for revision. The RUC submitted recommendations for 21 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

In October 2019, the identified five 010-day global period services more than one office visit based on 2018e Medicare utilization over 1,000, which was expanded to eight services to include the family of services. The RUC submitted eight recommendations for the 2021-2022 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

090-Day Global Codes

In January 2014, the RUC reviewed all 3,788, 090-day global codes to determine any outliers. Based on 2012 Medicare utilization data, 10 services were identified, that were reported at least 1,000 times per year and included more than six office visits. The RUC expanded the services identified in this screen to 38 to include additional codes as part of the family. The CPT® Editorial Panel deleted 8 services. The RUC submitted recommendations for 30 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

In October 2019, the identified three 090-day global period services more than six office visits based on 2018e Medicare utilization over 1,000. The RUC submitted recommendations for these three services for the 2021 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

High Level E/M in Global Period

In October 2015, the RUC reviewed all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had a level 5 office visits included. Seven services were identified that have a level 4 office visit included. The RUC expanded the list of services to 11 services to include additional codes as part of the family. The RUC confirmed that the level 4 post-operative visits were appropriate and well-defined for four services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules. The RUC noted that this screen will be complete after these services are reviewed because the RUC has more rigorously questioned level 4 office visits in the global period in recent years and will continue this process going forward. The RUC has completed review of the services under this screen.

000-Day Global Services Reported with an E/M with Modifier 25

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

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

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

In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The RUC recommended that two additional codes be removed from this screen as the specialty societies discovered that in fact an E/M as typical was considered in the survey process. Additional codes were added as part of the family of codes identified, totaling 22. The CPT Editorial Panel deleted one code and the RUC submitted 21 recommendations for the 2019 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Negative IWPUT
In October 2017, the RUC identified 22 services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC expanded the services identified in this screen to 56 services to include additional codes as part of the family. The CPT Editorial Panel deleted 15 services. The RUC submitted 41 recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Contractor Priced with High Volume
In April 2018, the RUC identified five contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000. The RUC expanded the services identified in this screen to seven to include additional codes as part of a family. The CPT Editorial Panel deleted two codes. The RUC submitted four recommendations for the 2020-2021 Medicare Physician Payment Schedule. The RUC will review the remaining service after two years of additional data is available.

CPT Modifier -51 Exempt List
In April 2018, the RUC identified seven services on the CPT Modifier -51 *Multiple Procedures* exempt list with 2017 estimated Medicare utilization over 10,000. The RUC examined the data provided on the percentage reported alone, physician pre and intra time and determined that this is an appropriate screen. The RUC recommended that four services be removed from the Modifier -51 exempt list and that three services remain on the list as they are separate and distinct services. The RUC notes that the CPT Editorial Panel will be reexamining this list in February 2019. The RUC has completed review of the services under this screen.

PE Units Screen
In April 2020, the RUC identified seven services with more than one median unit of service reported and a direct practice expense supply item unit cost greater than $100 based on 2018 Medicare utilization. In October 2020, the Practice Expense Subcommittee reviewed the supplies and kits identified to determine if any duplication occurs when reported in multiple units. The RUC determined that three of the seven codes identified had duplicative supplies. The RUC submitted new direct practice expense inputs for the 2022 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Public Comment Requests
In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year.

Final Rule for 2013
In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services, which was expanded to 39 services to include the entire code family. The RUC reviewed these services and recommended that eight services be removed from review as two G-codes lacked specialty society interest and six services are not potentially misvalued since there is no reliable way to determine an incremental difference from open thoracotomy to thorascopic procedures. The CPT Editorial Panel deleted two services. The RUC submitted recommendations for 29 services for the 2014-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2014
CMS did not receive any publicly nominated potentially misvalued codes for inclusion in the Proposed Rule for 2014. To broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified over a dozen services which CMS is proposing as potentially misvalued. The RUC reviewed these services and appropriate families, totaling 90 services. The CPT® Editorial Panel deleted 11 services. The RUC submitted recommendations to CMS for 79 services for the 2015-2018 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2015
In the Final Rule for 2015 the public and CMS nominated 26 services as potentially misvalued, which the RUC expanded to 53 services to include additional codes as part of this family. The CPT Editorial Panel deleted 16 services. The RUC submitted 37 recommendations for the 2016-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2016
In the Final Rule for 2016 the public and CMS nominated 25 services as potentially misvalued, which the RUC expanded to 53 services to include an additional code as part of the family. The CPT Editorial Panel deleted eight services. The RUC submitted 45 recommendations for the 2017-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2017
In the Final Rule for 2017 there were no public nominations for services in which the RUC was not already addressing.

Final Rule for 2018
In the Final Rule for 2018 the public and CMS nominated six services as potentially misvalued, which the RUC expanded to nine services. The RUC submitted nine recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2019
In the Final Rule for 2019 the public and CMS nominated nine services as potentially misvalued, which was expanded to 12 services as part of the family. The CPT Editorial Panel deleted two services. The RUC submitted 10 recommendations for the 2021 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Final Rule for 2020
In the Final Rule for 2020, the public and CMS nominated 10 services as potentially misvalued, which was expanded to 19 services as part of the family. The CPT Editorial Panel deleted four services. The submitted recommendations for eight services for the 2021 Medicare Physician Payment Schedule. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate. The RUC will review the remaining six services for the 2023 Medicare Physician Payment Schedule.

Final Rule for 2021
In the Final Rule for 2021, CMS received public nomination of two codes as potentially misvalued, which was expanded to 10 services to include the family. The RUC submitted 10 recommendations for the 2022-2023 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Work Neutrality
For every CPT code recommendation and family, the RUC submits utilization assumptions based on the specialty societies estimate for the next year of Medicare utilization. Starting with CPT 2009, the Relativity Assessment Workgroup began assessing all services for work neutrality. In 2012, the RUC confirmed that the RUC and specialty societies work neutrality calculation expectation is a zero change target. However, if actual work RVUs turn out to be 10% or greater than the former work RVUs for the family, the family should undergo review by the Relativity Assessment Workgroup. Three code families have been identified for re-examination, one from CPT 2009, CPT 2011 and CPT 2012. Two families were determined to have correct utilization assumptions after re-evaluating the coding structure and initial assumptions. The CPT 2012 family went through revisions at the CPT Editorial Panel as well as extensive educational efforts were engaged. However, after continued examination this family was resurveyed and the RUC submitted recommendations for four services for the 2022 Medicare Physician Payment Schedule.

Three additional code families were identified for re-examination from CPT 2018. One family appears to possibly be due to miscoding. All three families will be re-examined after additional utilization data are available.

Other Issues
In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for two codes and to maintain the work RVU for another code. CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT® Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining nine services for the 2011 Medicare Physician Payment Schedule.

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,629**
Codes Completed	**2,562**
Work and PE Maintained	679
Work Increased	316
Work Decreased	892
Direct Practice Expense Revised (beyond work changes)	179
Deleted from CPT®	496
Codes Under Review	**67**
Referred to CPT® Editorial Panel or CPT Assistant	40
RUC to Review for *CPT 2023*	5
RUC to review future review after additional data obtained	22

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

The RUC's efforts for 2009-2021 have resulted in more than $5 billion in annual redistribution within the Medicare Physician Payment Schedule.

Status Report: CMS Requests and Relativity Assessment Issues

00534 **Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,245

2021 Work RVU: 7.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

00537 **Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation**

Global: XXX **Issue:** Anesthesia for Cardiac Electrophysiologic Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 13 **Specialty Developing Recommendation:** ASA **First Identified:** October 2016 **2019 est Medicare Utilization:** 89,969

2021 Work RVU: 7.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 12 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

00560 **Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 58,933

2021 Work RVU: 15.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

00731 **Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,262,160

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5 base units **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 105,226

2021 Work RVU: 6.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6 base units **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

00740 **Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum**

Global: **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

00810 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum**

Global: **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00811 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,186,122

2021 Work RVU: 4.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4 base units **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

00812 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 517,650

2021 Work RVU: 3.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 3 base units **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

00813 **Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 492,977

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5 base units **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

00918 **Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus**

Global: XXX **Issue:** Anesthesia for transurethral procedures **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 101,565

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01916 **Anesthesia for diagnostic arteriography/venography** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 58,939

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

0191T **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion** **Global:** XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2019 est Medicare Utilization:** 57,829

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 17,980

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01935 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic**

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:** 19,793

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

01936 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic**

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** October 2016 **2019 est Medicare Utilization:** 311,884

2021 Work RVU: 5.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX2

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01XX3

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX4

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX5

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01XX6

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX7

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

0275T **Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar**

Global: YYY **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 2,656

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0376T **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,708

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

0379T **Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 49,050

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 3 years (Oct 2023) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

0394T **High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 28,857

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 3 years (Oct 2023) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0446T **Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training**

Global: 000 **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES **First Identified:** November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.14
2021 NF PE RVU: 53.70
2021 Fac PE RVU: 0.44

RUC Recommendation: Contractor Price **Referred to CPT** February 2021 **Result:** Contractor Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

0447T **Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision**

Global: 000 **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES **First Identified:** November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.34
2021 NF PE RVU: 1.55
2021 Fac PE RVU: 0.52

RUC Recommendation: Contractor Price **Referred to CPT** February 2021 **Result:** Contractor Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

0448T **Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation**

Global: 000 **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES **First Identified:** November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.91
2021 NF PE RVU: 53.16
2021 Fac PE RVU: 0.74

RUC Recommendation: Contractor Price **Referred to CPT** February 2021 **Result:** Contractor Price
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0449T **Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device**

Global: YYY **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 5,679

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

0474T **Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 12

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

0509T **Electroretinography (ERG) with interpretation and report, pattern (PERG)**

Global: XXX **Issue:** Electroretinography **Screen:** Work Neutrality 2019 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 41,106

2021 Work RVU: 0.40
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

0X12T

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO

First Identified: January 2021

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Contractor Price

Referred to CPT October 2020
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Contractor Price

Status Report: CMS Requests and Relativity Assessment Issues

10004 **Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 503

2021 Work RVU: 0.80
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

10005 **Fine needle aspiration biopsy, including ultrasound guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 145,323

2021 Work RVU: 1.46
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.63

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

10006 **Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 33,658

2021 Work RVU: 1.00
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

10007 **Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion** **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 395

2021 Work RVU: 1.81
2021 NF PE RVU: 7.06
2021 Fac PE RVU: 0.67

RUC Recommendation: 1.81 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10008 **Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 32

2021 Work RVU: 1.18
2021 NF PE RVU: 3.52
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10009 **Fine needle aspiration biopsy, including CT guidance; first lesion** **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,300

2021 Work RVU: 2.26
2021 NF PE RVU: 11.44
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.43 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10010 **Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 99

2021 Work RVU: 1.65
2021 NF PE RVU: 6.42
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

10011 **Fine needle aspiration biopsy, including MR guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 69

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

10012 **Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 21

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10021 **Fine needle aspiration biopsy, without imaging guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS Request - Final Rule for 2016 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 21 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,957

2021 Work RVU: 1.03
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.20 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Fine Needle Aspiration **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

10030 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 8,525

2021 Work RVU: 2.75
2021 NF PE RVU: 16.52
2021 Fac PE RVU: 0.94

RUC Recommendation: 3.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10040 **Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)**

Global: 010 **Issue:** Acne Surgery **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 13 **Specialty Developing Recommendation:** AAD **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,492

2021 Work RVU: 0.91
2021 NF PE RVU: 2.42
2021 Fac PE RVU: 0.52

RUC Recommendation: 0.91 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 368,976

2021 Work RVU: 1.22
2021 NF PE RVU: 2.27
2021 Fac PE RVU: 1.66

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

10061 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple**

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 134,001

2021 Work RVU: 2.45
2021 NF PE RVU: 3.45
2021 Fac PE RVU: 2.57

RUC Recommendation: Maintain. 2.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 12 **Specialty Developing Recommendation:** APMA, AAFP **First Identified:** April 2011 **2019 est Medicare Utilization:** 43,240

2021 Work RVU: 1.22
2021 NF PE RVU: 3.14
2021 Fac PE RVU: 1.68

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

10180 **Incision and drainage, complex, postoperative wound infection**

Global: 010 **Issue:** **Screen:** RUC identified when reviewing comparison codes **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** January 2013 **2019 est Medicare Utilization:** 9,692

2021 Work RVU: 2.30
2021 NF PE RVU: 4.99
2021 Fac PE RVU: 2.44

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11040 **Deleted from CPT**

Global: **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

11041 **Deleted from CPT**

Global: **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11042 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,938,307

2021 Work RVU: 1.01
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.12 **Referred to CPT** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11043 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 456,527

2021 Work RVU: 2.70
2021 NF PE RVU: 3.78
2021 Fac PE RVU: 1.40

RUC Recommendation: 3.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11044 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 88,567

2021 Work RVU: 4.10
2021 NF PE RVU: 4.42
2021 Fac PE RVU: 1.83

RUC Recommendation: 4.56 **Referred to CPT** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11045 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 492,140

2021 Work RVU: 0.50
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11046 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 239,254

2021 Work RVU: 1.03
2021 NF PE RVU: 0.94
2021 Fac PE RVU: 0.40

RUC Recommendation: 1.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11047 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,673

2021 Work RVU: 1.80
2021 NF PE RVU: 1.44
2021 Fac PE RVU: 0.71

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11055 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** APMA **First Identified:** November 2011 **2019 est Medicare Utilization:** 886,591

2021 Work RVU: 0.35
2021 NF PE RVU: 1.66
2021 Fac PE RVU: 0.08

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11056 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions**

Global: 000 **Issue:** Trim Skin Lesions **Screen:** MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,010,288

2021 Work RVU: 0.50
2021 NF PE RVU: 1.81
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11057 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** APMA **First Identified:** November 2011 **2019 est Medicare Utilization:** 346,586

2021 Work RVU: 0.65
2021 NF PE RVU: 1.88
2021 Fac PE RVU: 0.14

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11100 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion**

Global: **Issue:** Biopsy of Skin Lesion **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11101 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: **Issue:** Biopsy of Skin Lesion **Screen:** Low Value Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11102 **Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion**

Global: 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** February 2017 **2019 est Medicare Utilization:** 3,333,585

2021 Work RVU: 0.66
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 0.38

RUC Recommendation: 0.66 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11103 **Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** February 2017 **2019 est Medicare Utilization:** 1,456,282

2021 Work RVU: 0.38
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.38 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11104 **Punch biopsy of skin (including simple closure, when performed); single lesion** **Global:** 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 388,339

2021 Work RVU: 0.83
2021 NF PE RVU: 2.90
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.83 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11105 **Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 97,094

2021 Work RVU: 0.45
2021 NF PE RVU: 1.29
2021 Fac PE RVU: 0.25

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11106 **Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion** **Global:** 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 37,327

2021 Work RVU: 1.01
2021 NF PE RVU: 3.55
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.01 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11107 **Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 7,020

2021 Work RVU: 0.54
2021 NF PE RVU: 1.55
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.54 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

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

First Identified: January 2012 **2019 est Medicare Utilization:** 104,786

2021 Work RVU: 0.60
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.33

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

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

First Identified: January 2012 **2019 est Medicare Utilization:** 205,570

2021 Work RVU: 0.90
2021 NF PE RVU: 2.67
2021 Fac PE RVU: 0.50

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11302 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 114,770

2021 Work RVU: 1.05
2021 NF PE RVU: 3.02
2021 Fac PE RVU: 0.59

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11303 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 16,712

2021 Work RVU: 1.25
2021 NF PE RVU: 3.22
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11305 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 100,773

2021 Work RVU: 0.80
2021 NF PE RVU: 2.32
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11306 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 102,882

2021 Work RVU: 0.96
2021 NF PE RVU: 2.63
2021 Fac PE RVU: 0.39

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11307 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 51,111

2021 Work RVU: 1.20
2021 NF PE RVU: 2.95
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11308 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 14,010

2021 Work RVU: 1.46
2021 NF PE RVU: 2.93
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11310 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 74,188

2021 Work RVU: 0.80
2021 NF PE RVU: 2.60
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11311 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 100,460

2021 Work RVU: 1.10
2021 NF PE RVU: 2.89
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.43 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11312 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

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

First Identified: January 2012

2019 est Medicare Utilization: 46,378

2021 Work RVU: 1.30
2021 NF PE RVU: 3.26
2021 Fac PE RVU: 0.73

RUC Recommendation: 1.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

11313 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

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

First Identified: January 2012

2019 est Medicare Utilization: 8,180

2021 Work RVU: 1.68
2021 NF PE RVU: 3.60
2021 Fac PE RVU: 0.94

RUC Recommendation: 2.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

11719 **Trimming of nondystrophic nails, any number**

Global: 000 **Issue:** Debridement of Nail **Screen:** Low Value-High Volume **Complete?** Yes

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

First Identified: October 2010

2019 est Medicare Utilization: 837,707

2021 Work RVU: 0.17
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.04

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

11720 **Debridement of nail(s) by any method(s); 1 to 5**

Global: 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

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

First Identified: Septemer 2011

2019 est Medicare Utilization: 2,111,275

2021 Work RVU: 0.32
2021 NF PE RVU: 0.61
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.32 (Interim)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,784,854

2021 Work RVU: 0.54
2021 NF PE RVU: 0.72
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.54 (Interim) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11730 **Avulsion of nail plate, partial or complete, simple; single**

Global: 000 **Issue:** Removal of Nail Plate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 56 **Specialty Developing Recommendation:** APMA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,522

2021 Work RVU: 1.05
2021 NF PE RVU: 2.29
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Excision of Nail Bed - HCPAC **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 201,719

2021 Work RVU: 1.58
2021 NF PE RVU: 3.06
2021 Fac PE RVU: 1.25

RUC Recommendation: 1.99 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Excision of Nail Bed - HCPAC **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11755 **Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)**

Global: 000 **Issue:** Biopsy of Nail **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41i **Specialty Developing Recommendation:** APMA **First Identified:** July 2016 **2019 est Medicare Utilization:** 62,237

2021 Work RVU: 1.25
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAD **First Identified:** October 2009 **2019 est Medicare Utilization:** 265,694

2021 Work RVU: 0.52
2021 NF PE RVU: 1.08
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

11901 **Injection, intralesional; more than 7 lesions**

Global: 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAD **First Identified:** February 2010 **2019 est Medicare Utilization:** 73,970

2021 Work RVU: 0.80
2021 NF PE RVU: 1.17
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth2 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** April 2013 **2019 est Medicare Utilization:** 33,888

2021 Work RVU: 1.10
2021 NF PE RVU: 1.54
2021 Fac PE RVU: 0.39

RUC Recommendation: 1.10 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11981 **Insertion, non-biodegradable drug delivery implant**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 13,060

2021 Work RVU: 1.14
2021 NF PE RVU: 1.70
2021 Fac PE RVU: 0.52

RUC Recommendation: 1.30 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11982 **Removal, non-biodegradable drug delivery implant**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,500

2021 Work RVU: 1.34
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.70 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 2,345

2021 Work RVU: 1.91
2021 NF PE RVU: 2.03
2021 Fac PE RVU: 0.81

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 184,284

2021 Work RVU: 0.84
2021 NF PE RVU: 1.77
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12002 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 142,967

2021 Work RVU: 1.14
2021 NF PE RVU: 1.99
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.14 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12004 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 22,345

2021 Work RVU: 1.44
2021 NF PE RVU: 2.18
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12005 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 6,059

2021 Work RVU: 1.97
2021 NF PE RVU: 2.84
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12006 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,137

2021 Work RVU: 2.39
2021 NF PE RVU: 3.22
2021 Fac PE RVU: 0.59

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12007 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 357

2021 Work RVU: 2.90
2021 NF PE RVU: 3.42
2021 Fac PE RVU: 0.81

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12011 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 90,553

2021 Work RVU: 1.07
2021 NF PE RVU: 2.06
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12013 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 50,435

2021 Work RVU: 1.22
2021 NF PE RVU: 2.02
2021 Fac PE RVU: 0.26

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12014 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 6,842

2021 Work RVU: 1.57
2021 NF PE RVU: 2.37
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.57 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12015 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 3,321

2021 Work RVU: 1.98
2021 NF PE RVU: 2.74
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 526

2021 Work RVU: 2.68
2021 NF PE RVU: 3.30
2021 Fac PE RVU: 0.59

RUC Recommendation: 2.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 72

2021 Work RVU: 3.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.67

RUC Recommendation: 3.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 17

2021 Work RVU: 3.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.74

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12031 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 63,049

2021 Work RVU: 2.00
2021 NF PE RVU: 5.54
2021 Fac PE RVU: 2.15

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12032 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 280,457

2021 Work RVU: 2.52
2021 NF PE RVU: 6.28
2021 Fac PE RVU: 2.71

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

12034 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 25,707

2021 Work RVU: 2.97
2021 NF PE RVU: 6.53
2021 Fac PE RVU: 2.60

RUC Recommendation: 2.97 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

12035 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,889

2021 Work RVU: 3.50
2021 NF PE RVU: 7.58
2021 Fac PE RVU: 2.92

RUC Recommendation: 3.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12036 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,073

2021 Work RVU: 4.23
2021 NF PE RVU: 7.86
2021 Fac PE RVU: 3.22

RUC Recommendation: 4.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

12037 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 458

2021 Work RVU: 5.00
2021 NF PE RVU: 8.45
2021 Fac PE RVU: 3.61

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

12041 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 20,831

2021 Work RVU: 2.10
2021 NF PE RVU: 5.46
2021 Fac PE RVU: 1.86

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12042 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,449

2021 Work RVU: 2.79
2021 NF PE RVU: 6.05
2021 Fac PE RVU: 2.58

RUC Recommendation: 2.79 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12044 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,304

2021 Work RVU: 3.19
2021 NF PE RVU: 7.68
2021 Fac PE RVU: 2.57

RUC Recommendation: 3.19 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12045 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 337

2021 Work RVU: 3.75
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 3.48

RUC Recommendation: 3.90 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12046 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 89

2021 Work RVU: 4.30
2021 NF PE RVU: 9.67
2021 Fac PE RVU: 3.99

RUC Recommendation: 4.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12047 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 50

2021 Work RVU: 4.95
2021 NF PE RVU: 10.26
2021 Fac PE RVU: 4.23

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12051 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 54,376

2021 Work RVU: 2.33
2021 NF PE RVU: 5.76
2021 Fac PE RVU: 2.29

RUC Recommendation: 2.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12052 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 75,683

2021 Work RVU: 2.87
2021 NF PE RVU: 6.10
2021 Fac PE RVU: 2.58

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

12053 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,218

2021 Work RVU: 3.17
2021 NF PE RVU: 7.28
2021 Fac PE RVU: 2.66

RUC Recommendation: 3.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12054 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,576

2021 Work RVU: 3.50
2021 NF PE RVU: 7.45
2021 Fac PE RVU: 2.32

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12055 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 281

2021 Work RVU: 4.50
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 3.43

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12056 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 41

2021 Work RVU: 5.30
2021 NF PE RVU: 11.05
2021 Fac PE RVU: 5.03

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12057 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 25

2021 Work RVU: 6.00
2021 NF PE RVU: 11.25
2021 Fac PE RVU: 5.28

RUC Recommendation: 6.28 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13100 **Repair, complex, trunk; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 6,433

2021 Work RVU: 3.00
2021 NF PE RVU: 6.88
2021 Fac PE RVU: 2.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13101 **Repair, complex, trunk; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 102,897

2021 Work RVU: 3.50
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 3.38

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13102 **Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 26,791

2021 Work RVU: 1.24
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,693

2021 Work RVU: 3.23
2021 NF PE RVU: 7.04
2021 Fac PE RVU: 3.22

RUC Recommendation: 3.23 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 207,941

2021 Work RVU: 4.00
2021 NF PE RVU: 8.34
2021 Fac PE RVU: 3.08

RUC Recommendation: 4.00 **Referred to CPT** September 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

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

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 31,342

2021 Work RVU: 1.44
2021 NF PE RVU: 2.18
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

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

Global: 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 41,454

2021 Work RVU: 3.73
2021 NF PE RVU: 7.46
2021 Fac PE RVU: 2.90

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13132 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 309,273

2021 Work RVU: 4.78
2021 NF PE RVU: 8.81
2021 Fac PE RVU: 3.52

RUC Recommendation: 4.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

13133 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 17,262

2021 Work RVU: 2.19
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 2.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

13150 **Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**

Global: **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

13151 **Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 33,842

2021 Work RVU: 4.34
2021 NF PE RVU: 7.79
2021 Fac PE RVU: 3.26

RUC Recommendation: 4.34 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13152 **Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 54,926

2021 Work RVU: 5.34
2021 NF PE RVU: 8.93
2021 Fac PE RVU: 3.83

RUC Recommendation: 5.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13153 **Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 938

2021 Work RVU: 2.38
2021 NF PE RVU: 2.80
2021 Fac PE RVU: 1.28

RUC Recommendation: 2.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14000 **Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 7,303

2021 Work RVU: 6.37
2021 NF PE RVU: 11.17
2021 Fac PE RVU: 7.16

RUC Recommendation: 6.19 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14001 **Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,637

2021 Work RVU: 8.78
2021 NF PE RVU: 13.39
2021 Fac PE RVU: 8.68

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14020 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 17,817

2021 Work RVU: 7.22
2021 NF PE RVU: 12.29
2021 Fac PE RVU: 8.16

RUC Recommendation: 7.02 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14021 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,350

2021 Work RVU: 9.72
2021 NF PE RVU: 14.29
2021 Fac PE RVU: 9.54

RUC Recommendation: 9.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14040 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 67,406

2021 Work RVU: 8.60
2021 NF PE RVU: 12.51
2021 Fac PE RVU: 8.42

RUC Recommendation: 8.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14041 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 45,011

2021 Work RVU: 10.83
2021 NF PE RVU: 14.84
2021 Fac PE RVU: 9.98

RUC Recommendation: 10.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14060 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 90,113

2021 Work RVU: 9.23
2021 NF PE RVU: 12.12
2021 Fac PE RVU: 8.93

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14061 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 31,224

2021 Work RVU: 11.48
2021 NF PE RVU: 16.18
2021 Fac PE RVU: 10.86

RUC Recommendation: 11.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14300 **Deleted from CPT**

Global: **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm**

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

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 38,864

2021 Work RVU: 12.65
2021 NF PE RVU: 17.28
2021 Fac PE RVU: 10.74

RUC Recommendation: 12.47 **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

14302 **Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 40,086

2021 Work RVU: 3.73
2021 NF PE RVU: 1.96
2021 Fac PE RVU: 1.96

RUC Recommendation: 3.73 **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15002 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 24,066

2021 Work RVU: 3.65
2021 NF PE RVU: 6.16
2021 Fac PE RVU: 2.17

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15004 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 32,464

2021 Work RVU: 4.58
2021 NF PE RVU: 6.61
2021 Fac PE RVU: 2.44

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15100 **Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,549

2021 Work RVU: 9.90
2021 NF PE RVU: 13.91
2021 Fac PE RVU: 9.16

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,650

2021 Work RVU: 10.15
2021 NF PE RVU: 13.24
2021 Fac PE RVU: 8.42

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15170 **Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15171 **Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15175 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15176 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less**

Global: 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,947

2021 Work RVU: 8.09
2021 NF PE RVU: 13.42
2021 Fac PE RVU: 8.53

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

15240 **Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, AAD **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,328

2021 Work RVU: 10.41
2021 NF PE RVU: 15.47
2021 Fac PE RVU: 11.30

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

15271 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 111,779

2021 Work RVU: 1.50
2021 NF PE RVU: 2.83
2021 Fac PE RVU: 0.73

RUC Recommendation: 1.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15272 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 14,569

2021 Work RVU: 0.33
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15273 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,775

2021 Work RVU: 3.50
2021 NF PE RVU: 5.22
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15274 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 25,402

2021 Work RVU: 0.80
2021 NF PE RVU: 1.48
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15275 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 122,551

2021 Work RVU: 1.83
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.83 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15276 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15277 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,720

2021 Work RVU: 4.00
2021 NF PE RVU: 5.53
2021 Fac PE RVU: 1.89

RUC Recommendation: 4.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,936

2021 Work RVU: 1.00
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15320 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15321 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15330 **Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15331 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15335 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15336 **Deleted from CPT** **Global:** **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15366 **Deleted from CPT**

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

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 **Deleted from CPT**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15401 **Deleted from CPT**

Global: **Issue:** Xenograft **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACS, ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15420 **Deleted from CPT**

Global: **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15421 **Deleted from CPT** **Global:** **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 292

2021 Work RVU: 10.21
2021 NF PE RVU: 14.85
2021 Fac PE RVU: 9.36

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 691

2021 Work RVU: 10.12
2021 NF PE RVU: 14.00
2021 Fac PE RVU: 9.64

RUC Recommendation: 9.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 10.70
2021 NF PE RVU: 13.68
2021 Fac PE RVU: 9.34

RUC Recommendation: 10.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,346

2021 Work RVU: 9.37
2021 NF PE RVU: 12.76
2021 Fac PE RVU: 8.61

RUC Recommendation: 9.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15730 **Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAO **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,767

2021 Work RVU: 13.50
2021 NF PE RVU: 28.61
2021 Fac PE RVU: 11.48

RUC Recommendation: 13.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15731 **Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,362

2021 Work RVU: 14.38
2021 NF PE RVU: 16.41
2021 Fac PE RVU: 12.59

RUC Recommendation: Not part of family **Referred to CPT** September 2016 **Result:** Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15732 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)**

Global: **Issue:** Muscle Flaps **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15733 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2017 **2019 est Medicare Utilization:** 5,657

2021 Work RVU: 15.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.20

RUC Recommendation: 15.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15734 **Muscle, myocutaneous, or fasciocutaneous flap; trunk**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,232

2021 Work RVU: 23.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.46

RUC Recommendation: 23.00 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15736 **Muscle, myocutaneous, or fasciocutaneous flap; upper extremity** **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASSH, ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,501

2021 Work RVU: 17.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: 17.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15738 **Muscle, myocutaneous, or fasciocutaneous flap; lower extremity** **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 6,218

2021 Work RVU: 19.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.12

RUC Recommendation: 19.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15740 **Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel** **Global:** 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,046

2021 Work RVU: 11.80
2021 NF PE RVU: 15.93
2021 Fac PE RVU: 10.87

RUC Recommendation: 11.57 **Referred to CPT** February 2009 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15769 **Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOHNS, ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.24

RUC Recommendation: 6.68. Flagged for RAW review April 2022. **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15771 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.73
2021 NF PE RVU: 8.97
2021 Fac PE RVU: 6.08

RUC Recommendation: 6.73 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15772 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 1.15

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15773 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate**

Global: 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.83
2021 NF PE RVU: 9.01
2021 Fac PE RVU: 6.12

RUC Recommendation: 6.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15774 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.41
2021 NF PE RVU: 2.30
2021 Fac PE RVU: 1.11

RUC Recommendation: 2.41 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,429

2021 Work RVU: 3.65
2021 NF PE RVU: 1.97
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.65 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

157X1

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 8.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15823 **Blepharoplasty, upper eyelid; with excessive skin weighting down lid**

Global: 090 **Issue:** Upper Eyelid Blepharoplasty **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 33 **Specialty Developing Recommendation:** AAO **First Identified:** October 2009 **2019 est Medicare Utilization:** 97,994

2021 Work RVU: 6.81
2021 NF PE RVU: 10.71
2021 Fac PE RVU: 8.60

RUC Recommendation: 6.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

16020 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 15,272

2021 Work RVU: 0.71
2021 NF PE RVU: 1.66
2021 Fac PE RVU: 0.77

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

16025 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,908

2021 Work RVU: 1.74
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 1.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

16030 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACEP, ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 879

2021 Work RVU: 2.08
2021 NF PE RVU: 3.28
2021 Fac PE RVU: 1.38

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2012

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

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,117,793

2021 Work RVU: 0.61
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Destruction of Premalignant Lesions **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,474,499

2021 Work RVU: 0.04
2021 NF PE RVU: 0.15
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17004 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** CMS High Expenditure Procedural Codes1 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 874,685

2021 Work RVU: 1.37
2021 NF PE RVU: 3.35
2021 Fac PE RVU: 1.34

RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,933

2021 Work RVU: 3.69
2021 NF PE RVU: 5.92
2021 Fac PE RVU: 3.87

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,449

2021 Work RVU: 4.79
2021 NF PE RVU: 7.74
2021 Fac PE RVU: 5.00

RUC Recommendation: 4.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,081

2021 Work RVU: 7.49
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 6.78

RUC Recommendation: 6.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17110 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,556,286

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: 1.15

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17111 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 122,909

2021 Work RVU: 0.97
2021 NF PE RVU: 2.84
2021 Fac PE RVU: 1.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

17250 **Chemical cauterization of granulation tissue (ie, proud flesh)**

Global: 000 **Issue:** RAW **Screen:** High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 234,080

2021 Work RVU: 0.50
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 0.50

RUC Recommendation: Review in 2 years (Jan 2022). **Referred to CPT** September 2016 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

17261 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 140,325

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 1.17

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17262 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 287,333

2021 Work RVU: 1.63
2021 NF PE RVU: 3.45
2021 Fac PE RVU: 1.40

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17271 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 53,690

2021 Work RVU: 1.54
2021 NF PE RVU: 3.18
2021 Fac PE RVU: 1.35

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17272 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 82,281

2021 Work RVU: 1.82
2021 NF PE RVU: 3.54
2021 Fac PE RVU: 1.51

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17281 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 86,818

2021 Work RVU: 1.77
2021 NF PE RVU: 3.33
2021 Fac PE RVU: 1.48

RUC Recommendation: 1.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17282 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 81,831

2021 Work RVU: 2.09
2021 NF PE RVU: 3.74
2021 Fac PE RVU: 1.66

RUC Recommendation: 2.09 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17311 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 829,586

2021 Work RVU: 6.20
2021 NF PE RVU: 12.99
2021 Fac PE RVU: 3.57

RUC Recommendation: 6.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17312 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 509,267

2021 Work RVU: 3.30
2021 NF PE RVU: 8.41
2021 Fac PE RVU: 1.89

RUC Recommendation: 3.30 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17313 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 140,796

2021 Work RVU: 5.56
2021 NF PE RVU: 12.49
2021 Fac PE RVU: 3.20

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 57,990

2021 Work RVU: 3.06
2021 NF PE RVU: 8.16
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 19,946

2021 Work RVU: 0.87
2021 NF PE RVU: 1.30
2021 Fac PE RVU: 0.50

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,614

2021 Work RVU: 3.83
2021 NF PE RVU: 9.57
2021 Fac PE RVU: 4.50

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

19081 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60,561

2021 Work RVU: 3.29
2021 NF PE RVU: 13.26
2021 Fac PE RVU: 1.19

RUC Recommendation: 3.29 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19082 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 4,476

2021 Work RVU: 1.65
2021 NF PE RVU: 11.70
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.65 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19083 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 118,588

2021 Work RVU: 3.10
2021 NF PE RVU: 13.47
2021 Fac PE RVU: 1.12

RUC Recommendation: 3.10 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19084 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 15,269

2021 Work RVU: 1.55
2021 NF PE RVU: 11.57
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.55 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19085 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,634

2021 Work RVU: 3.64
2021 NF PE RVU: 22.01
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.64 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19086 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,195

2021 Work RVU: 1.82
2021 NF PE RVU: 18.59
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.82 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19103 **Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19281 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 30,514

2021 Work RVU: 2.00
2021 NF PE RVU: 5.08
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19282 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,292

2021 Work RVU: 1.00
2021 NF PE RVU: 4.08
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19283 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19284 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 338

2021 Work RVU: 1.00
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19285 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,714

2021 Work RVU: 1.70
2021 NF PE RVU: 10.83
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.70 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19286 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 2,002

2021 Work RVU: 0.85
2021 NF PE RVU: 9.77
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.85 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19287 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 266

2021 Work RVU: 2.55
2021 NF PE RVU: 19.02
2021 Fac PE RVU: 0.92

RUC Recommendation: 3.02 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19288 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60

2021 Work RVU: 1.28
2021 NF PE RVU: 15.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.51 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19290 **Preoperative placement of needle localization wire, breast;**

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)**

Global: **Issue:** Breast Biopsy **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19303 **Mastectomy, simple, complete**

Global: 090 **Issue:** Mastectomy **Screen:** Site of Service Anomaly - 2015 / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACS, ASBS **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,587

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19307 **Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle**

Global: 090 **Issue:** Modified Radical Mastectomy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 22 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 6,042

2021 Work RVU: 17.99
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.69

RUC Recommendation: 17.99 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19318 **Breast reduction**

Global: 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,501

2021 Work RVU: 16.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.22

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19340 **Insertion of breast implant on same day of mastectomy (ie, immediate)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** CMS Request / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,433

2021 Work RVU: 10.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: 11.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19357 **Tissue expander placement in breast reconstruction, including subsequent expansion(s)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** Site of Service Anomaly / 090-Day Global Post-Operative Visits / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.67

RUC Recommendation: 15.36 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 **Deleted from CPT**

Global: **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20005 **Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)**

Global: **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

20220 **Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2018 **2019 est Medicare Utilization:** 12,355

2021 Work RVU: 1.65
2021 NF PE RVU: 5.58
2021 Fac PE RVU: 0.75

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20225 **Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 14,341

2021 Work RVU: 2.45
2021 NF PE RVU: 9.49
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20240 **Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** April 2014 **2019 est Medicare Utilization:** 6,533

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20245 **Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)** **Global:** 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,354

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.17

RUC Recommendation: 6.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,693

2021 Work RVU: 3.54
2021 NF PE RVU: 10.08
2021 Fac PE RVU: 3.09

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

20526 **Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel** **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 102,673

2021 Work RVU: 0.94
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.57

RUC Recommendation: Remove fromm screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")**

Global: 000 **Issue:** Injection of Tendon **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, AAPM&R, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 848,059

2021 Work RVU: 0.75
2021 NF PE RVU: 0.80
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20551 **Injection(s); single tendon origin/insertion**

Global: 000 **Issue:** Therapeutic Injection Carpal Tunnel **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAPMR, AAOS, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 163,234

2021 Work RVU: 0.75
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20552 **Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 350,677

2021 Work RVU: 0.66
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.66 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20553 **Injection(s); single or multiple trigger point(s), 3 or more muscles**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,100

2021 Work RVU: 0.75
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20600 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance**

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

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 444,325

2021 Work RVU: 0.66
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.66 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20604 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 46,354

2021 Work RVU: 0.89
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.89 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20605 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance**

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

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 466,622

2021 Work RVU: 0.68
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.68 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20606 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 56,334

2021 Work RVU: 1.00
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20610 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,722,382

2021 Work RVU: 0.79
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.79 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20611 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,069,935

2021 Work RVU: 1.10
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.10 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20612 **Aspiration and/or injection of ganglion cyst(s) any location**

Global: 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 28,400

2021 Work RVU: 0.70
2021 NF PE RVU: 1.06
2021 Fac PE RVU: 0.41

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

20680 **Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 55,761

2021 Work RVU: 5.96
2021 NF PE RVU: 11.22
2021 Fac PE RVU: 5.36

RUC Recommendation: 5.96 and adjustments to pre-service time package 3. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20692 **Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)**

Global: 090 **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 3,150

2021 Work RVU: 16.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.87

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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

Global: 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

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

First Identified: September 2007 **2019 est Medicare Utilization:** 6,209

2021 Work RVU: 4.28
2021 NF PE RVU: 7.72
2021 Fac PE RVU: 4.95

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

20700 **Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

20701 **Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.13
2021 NF PE RVU: 0.51
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

20702 **Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.14
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20703 **Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.80
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20704 **Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.60
2021 NF PE RVU: 1.19
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20705 **Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.15
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.98

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 3.00
2021 NF PE RVU: 8.60
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20902 **Bone graft, any donor area; major or large** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 4,599

2021 Work RVU: 4.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.76

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)** **Global:** **Issue:** Tissue Grafting Procedures **Screen:** CMS Fastest Growing / Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, ASPS, AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,815

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted for 2020

21015 **Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 506

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.04

RUC Recommendation: 9.71 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible**

Global: 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 61 **Specialty Developing Recommendation:** AAOMS

First Identified: September 2007 **2019 est Medicare Utilization:** 3,614

2021 Work RVU: 10.03
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 8.55

RUC Recommendation: 10.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

21495 **Open treatment of hyoid fracture**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

21557 **Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 490

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.39

RUC Recommendation: 14.57

Referred to CPT June 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

21800 **Closed treatment of rib fracture, uncomplicated, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

21805 **Open treatment of rib fracture without fixation, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21810 **Treatment of rib fracture requiring external fixation (flail chest)**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21811 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 357

2021 Work RVU: 10.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.31

RUC Recommendation: 19.55 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21812 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 468

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.32

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21813 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 62

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.08

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21820 **Closed treatment of sternum fracture**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 1.36
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 2.69

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

21825 **Open treatment of sternum fracture with or without skeletal fixation**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 737

2021 Work RVU: 7.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: Unrelated to the family **Referred to CPT** October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21935 **Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 235

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.11

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22214 **Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,695

2021 Work RVU: 21.02
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.74

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22305 **Closed treatment of vertebral process fracture(s)**

Global: **Issue:** Closed treatment of vertebral process fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 23 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22310 **Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing**

Global: 090 **Issue:** Closed Treatment Vertebral Fracture **Screen:** Negative IWPUT / Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 23 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** April 2017 **2019 est Medicare Utilization:** 6,942

2021 Work RVU: 3.45
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.53

RUC Recommendation: 3.45. Flag for Rereview **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22510 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,686

2021 Work RVU: 7.90
2021 NF PE RVU: 47.52
2021 Fac PE RVU: 3.71

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22511 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 4,104

2021 Work RVU: 7.33
2021 NF PE RVU: 47.95
2021 Fac PE RVU: 3.58

RUC Recommendation: 8.05 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22512 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 2,505

2021 Work RVU: 4.00
2021 NF PE RVU: 19.83
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22513 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 24,396

2021 Work RVU: 8.65
2021 NF PE RVU: 185.14
2021 Fac PE RVU: 4.81

RUC Recommendation: 8.90 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22514 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 26,776

2021 Work RVU: 7.99
2021 NF PE RVU: 185.16
2021 Fac PE RVU: 4.57

RUC Recommendation: 8.24 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22515 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 15,688

2021 Work RVU: 4.00
2021 NF PE RVU: 100.20
2021 Fac PE RVU: 1.68

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22520 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22521 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22522 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22523 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22524 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22525 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 908

2021 Work RVU: 24.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.10

RUC Recommendation: Remove from screen. CPT Assistant article published. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 40,145

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.59

RUC Recommendation: 24.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22552 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,696

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.20

RUC Recommendation: 6.50 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,675

2021 Work RVU: 17.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.17

RUC Recommendation: 17.69 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22558 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** High Volume Growth2 / Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,376

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22585 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 17,132

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.57

RUC Recommendation: Remove from screen **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22612 **Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,894

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.98

RUC Recommendation: Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22614 **Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 144,296

2021 Work RVU: 6.43
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.43 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22630 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,654

2021 Work RVU: 22.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.38

RUC Recommendation: 22.09 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22632 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 5.22 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22633 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,096

2021 Work RVU: 27.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.89

RUC Recommendation: 27.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22634 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,338

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.16 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,692

2021 Work RVU: 13.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.67

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

22849 **Reinsertion of spinal fixation device**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 4,231

2021 Work RVU: 19.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.05

RUC Recommendation: Maintain **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS Fastest Growing / High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22859 **Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,934

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22867 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level**

Global: 090 **Issue:** Insertion of Interlaminar/Interspinous Device **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,131

2021 Work RVU: 13.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.54

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22868 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 532

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22900 **Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 628

2021 Work RVU: 8.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 8.21 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

23076 **Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 677

2021 Work RVU: 7.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.02

RUC Recommendation: 7.28 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 **Claviculectomy; partial**

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

Most Recent RUC Meeting: April 2008 **Tab:** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,767

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.52

RUC Recommendation: 7.23 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release**

Global: 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,826

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23350 **Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography**

Global: 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 35,070

2021 Work RVU: 1.00
2021 NF PE RVU: 3.80
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

23405 **Tenotomy, shoulder area; single tendon**

Global: 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,277

2021 Work RVU: 8.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23410 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute**

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

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,333

2021 Work RVU: 11.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: 11.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23412 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 12,002

2021 Work RVU: 11.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.91

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 62 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 408

2021 Work RVU: 9.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,359

2021 Work RVU: 13.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.52

RUC Recommendation: 13.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23430 **Tenodesis of long tendon of biceps**

Global: 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,997

2021 Work RVU: 10.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 10.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,487

2021 Work RVU: 10.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.61

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))**

Global: 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 67,382

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

23540 **Closed treatment of acromioclavicular dislocation; without manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 339

2021 Work RVU: 2.36
2021 NF PE RVU: 4.19
2021 Fac PE RVU: 4.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 14 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,747

2021 Work RVU: 3.00
2021 NF PE RVU: 6.32
2021 Fac PE RVU: 5.76

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23625 **Closed treatment of greater humeral tuberosity fracture; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 173

2021 Work RVU: 4.10
2021 NF PE RVU: 6.43
2021 Fac PE RVU: 5.50

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23650 **Closed treatment of shoulder dislocation, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,692

2021 Work RVU: 3.53
2021 NF PE RVU: 5.37
2021 Fac PE RVU: 4.47

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23655 **Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,327

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

23665 **Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 556

2021 Work RVU: 4.66
2021 NF PE RVU: 7.24
2021 Fac PE RVU: 6.24

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24505 **Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 890

2021 Work RVU: 5.39
2021 NF PE RVU: 8.49
2021 Fac PE RVU: 6.96

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24600 **Treatment of closed elbow dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,283

2021 Work RVU: 4.37
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 4.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24605 **Treatment of closed elbow dislocation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 382

2021 Work RVU: 5.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: October 2010 **Tab:** 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,034

2021 Work RVU: 7.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 7.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25210 **Carpectomy; 1 bone**

Global: 090 **Issue:** Carpectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,150

2021 Work RVU: 6.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.35

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 919

2021 Work RVU: 8.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.21

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,402

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

Most Recent RUC Meeting: February 2008 **Tab:** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,690

2021 Work RVU: 8.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.81

RUC Recommendation: 7.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

25565 **Closed treatment of radial and ulnar shaft fractures; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 667

2021 Work RVU: 5.85
2021 NF PE RVU: 8.38
2021 Fac PE RVU: 6.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

25605 **Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,527

2021 Work RVU: 6.25
2021 NF PE RVU: 8.59
2021 Fac PE RVU: 7.68

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

25606 **Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 2,015

2021 Work RVU: 8.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.77

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25607 **Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 9,419

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.43

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25608 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 7,290

2021 Work RVU: 11.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.23

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25609 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** January 2014 **2019 est Medicare Utilization:** 18,114

2021 Work RVU: 14.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.92

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25675 **Closed treatment of distal radioulnar dislocation with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 445

2021 Work RVU: 4.89
2021 NF PE RVU: 7.39
2021 Fac PE RVU: 6.10

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26020 **Drainage of tendon sheath, digit and/or palm, each**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 2,453

2021 Work RVU: 6.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.34

RUC Recommendation: 7.79

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26055 **Tendon sheath incision (eg, for trigger finger)**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 105,433

2021 Work RVU: 3.11
2021 NF PE RVU: 13.80
2021 Fac PE RVU: 4.93

RUC Recommendation: 3.75

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each**

Global: 090 **Issue:** RAW **Screen:** Site of Service Anomaly / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,997

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: Action plan for RAW Oct 2015. Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2012

26160 **Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 18,598

2021 Work RVU: 3.57
2021 NF PE RVU: 13.97
2021 Fac PE RVU: 5.13

RUC Recommendation: 3.57 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,150

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.28

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26357 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 66

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.25

RUC Recommendation: 11.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26358 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 42

2021 Work RVU: 12.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.08

RUC Recommendation: 13.10 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon**

Global: 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 10,824

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.38

RUC Recommendation: 6.76 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

26700 **Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 471

2021 Work RVU: 3.83
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 4.61

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

26750 **Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,976

2021 Work RVU: 1.80
2021 NF PE RVU: 3.40
2021 Fac PE RVU: 3.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26755 **Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 522

2021 Work RVU: 3.23
2021 NF PE RVU: 5.67
2021 Fac PE RVU: 4.32

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26770 **Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,900

2021 Work RVU: 3.15
2021 NF PE RVU: 4.68
2021 Fac PE RVU: 3.93

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27048 **Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 339

2021 Work RVU: 8.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.31

RUC Recommendation: 8.74 **Referred to CPT** June 2008 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Most Recent RUC Meeting: April 2008 **Tab:** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,884

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.60

RUC Recommendation: 5.66 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: April 2011 **Tab:** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 489,612

2021 Work RVU: 1.48
2021 NF PE RVU: 3.26
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.48 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27130 **Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft** **Global:** 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 169,584

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.40

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27134 **Revision of total hip arthroplasty; both components, with or without autograft or allograft**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,863

2021 Work RVU: 30.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.86

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27193 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

27194 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27197 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 11,080

2021 Work RVU: 1.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.07

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27198 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.74

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27220 **Closed treatment of acetabulum (hip socket) fracture(s); without manipulation**

Global: 090 **Issue:** Closed Treatment Fracture - Hip **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 08 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2017 **2019 est Medicare Utilization:** 3,070

2021 Work RVU: 5.50
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 5.61

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27230 **Closed treatment of femoral fracture, proximal end, neck; without manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,509

2021 Work RVU: 5.81
2021 NF PE RVU: 7.43
2021 Fac PE RVU: 7.17

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27232 **Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 194

2021 Work RVU: 11.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27236 **Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement** **Global:** 090 **Issue:** Open Treatment of Femoral Fracture **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2011 **2019 est Medicare Utilization:** 57,280

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.10

RUC Recommendation: 17.61 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27240 **Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 260

2021 Work RVU: 13.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,947

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.43

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 83,430

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.41

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia**

Global: 000 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,180

2021 Work RVU: 3.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.82 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27252 **Closed treatment of hip dislocation, traumatic; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 762

2021 Work RVU: 11.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27265 **Closed treatment of post hip arthroplasty dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,333

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.75

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27266 **Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,456

2021 Work RVU: 7.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.98

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27279 **Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device** **Global:** 090 **Issue:** Arthodesis - Sacroiliac Joint **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** July 2017 **2019 est Medicare Utilization:** 3,753

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.28

RUC Recommendation: 9.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 814

2021 Work RVU: 5.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27369 **Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography**

Global: 000 **Issue:** Knee Arthrography Injection **Screen:** Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** June 2017 **2019 est Medicare Utilization:** 60,267

2021 Work RVU: 0.77
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** February 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27370 **Injection of contrast for knee arthrography**

Global: **Issue:** Knee Arthrography Injection **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Bulletin #1 2010

Status Report: CMS Requests and Relativity Assessment Issues

27446 **Arthroplasty, knee, condyle and plateau; medial OR lateral compartment**

Global: 090 **Issue:** Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than $10 million / Site of Service Anomaly - 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,803

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.11

RUC Recommendation: 17.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27447 **Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)**

Global: 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 312,130

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.37

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27502 **Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 385

2021 Work RVU: 11.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.76

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27510 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 386

2021 Work RVU: 9.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27550 **Closed treatment of knee dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 531

2021 Work RVU: 5.98
2021 NF PE RVU: 8.46
2021 Fac PE RVU: 7.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27552 **Closed treatment of knee dislocation; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 269

2021 Work RVU: 8.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

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

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 211

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.22

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27619 **Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 552

2021 Work RVU: 6.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.54

RUC Recommendation: 6.80 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27640 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,673

2021 Work RVU: 12.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.13

RUC Recommendation: 12.10 **Referred to CPT** June 2008 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27641 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 905

2021 Work RVU: 9.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.91

RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27650 **Repair, primary, open or percutaneous, ruptured Achilles tendon;**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 9.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.78

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27654 **Repair, secondary, Achilles tendon, with or without graft**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,117

2021 Work RVU: 10.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 10.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,084

2021 Work RVU: 6.69
2021 NF PE RVU: 12.08
2021 Fac PE RVU: 6.05

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27687 **Gastrocnemius recession (eg, Strayer procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,093

2021 Work RVU: 6.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)**

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

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,376

2021 Work RVU: 9.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.39

RUC Recommendation: 8.96 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)**

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

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,579

2021 Work RVU: 10.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.72

RUC Recommendation: 10.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27752 **Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,229

2021 Work RVU: 6.27
2021 NF PE RVU: 8.42
2021 Fac PE RVU: 7.06

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27762 **Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 369

2021 Work RVU: 5.47
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 6.33

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27792 **Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed**

Global: 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,279

2021 Work RVU: 8.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.74

RUC Recommendation: 9.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27810 **Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,962

2021 Work RVU: 5.32
2021 NF PE RVU: 7.64
2021 Fac PE RVU: 6.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27814 **Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,858

2021 Work RVU: 10.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.01

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation** **Global:** 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,490

2021 Work RVU: 5.69
2021 NF PE RVU: 7.71
2021 Fac PE RVU: 6.15

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27825 **Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 659

2021 Work RVU: 6.69
2021 NF PE RVU: 8.17
2021 Fac PE RVU: 6.59

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27840 **Closed treatment of ankle dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,234

2021 Work RVU: 4.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.53

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

28001 **Incision and drainage, bursa, foot**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 3,770

2021 Work RVU: 2.78
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.87

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28002 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,661

2021 Work RVU: 5.34
2021 NF PE RVU: 7.01
2021 Fac PE RVU: 3.34

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28003 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas**

Global: 090 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 5,470

2021 Work RVU: 9.06
2021 NF PE RVU: 10.59
2021 Fac PE RVU: 6.33

RUC Recommendation: 5.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 5.15
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 3.71

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,154

2021 Work RVU: 7.31
2021 NF PE RVU: 11.80
2021 Fac PE RVU: 6.30

RUC Recommendation: 8.27 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 14,469

2021 Work RVU: 6.76
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 5.30

RUC Recommendation: 7.72 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe**

Global: 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 11,425

2021 Work RVU: 5.00
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 4.25

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28285 **Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)**

Global: 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 71,537

2021 Work RVU: 5.62
2021 NF PE RVU: 9.73
2021 Fac PE RVU: 4.95

RUC Recommendation: 5.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28289 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,662

2021 Work RVU: 6.90
2021 NF PE RVU: 13.18
2021 Fac PE RVU: 5.72

RUC Recommendation: 6.90 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28290 **Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

28291 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,067

2021 Work RVU: 8.01
2021 NF PE RVU: 12.74
2021 Fac PE RVU: 5.60

RUC Recommendation: 8.01 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28292 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,950

2021 Work RVU: 7.44
2021 NF PE RVU: 12.86
2021 Fac PE RVU: 5.88

RUC Recommendation: 7.44 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28293 **Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

28294 **Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28295 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 586

2021 Work RVU: 8.57
2021 NF PE RVU: 23.38
2021 Fac PE RVU: 8.29

RUC Recommendation: 8.57 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28296 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method**

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

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,559

2021 Work RVU: 8.25
2021 NF PE RVU: 17.86
2021 Fac PE RVU: 5.94

RUC Recommendation: 8.25 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28297 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,793

2021 Work RVU: 9.29
2021 NF PE RVU: 20.85
2021 Fac PE RVU: 7.24

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28298 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,903

2021 Work RVU: 7.75
2021 NF PE RVU: 16.46
2021 Fac PE RVU: 6.00

RUC Recommendation: 7.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28299 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,743

2021 Work RVU: 9.29
2021 NF PE RVU: 19.90
2021 Fac PE RVU: 6.82

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28300 **Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,519

2021 Work RVU: 9.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.88

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 5.57
2021 NF PE RVU: 10.09
2021 Fac PE RVU: 4.37

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28470 **Closed treatment of metatarsal fracture; without manipulation, each**

Global: 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2019 est Medicare Utilization:** 29,629

2021 Work RVU: 2.03
2021 NF PE RVU: 4.14
2021 Fac PE RVU: 3.72

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28660 **Closed treatment of interphalangeal joint dislocation; without anesthesia**

Global: 010 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 689

2021 Work RVU: 1.28
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 1.21

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

28725 **Arthrodesis; subtalar**

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

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,389

2021 Work RVU: 11.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.84

RUC Recommendation: 12.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**

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

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,581

2021 Work RVU: 10.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.25

RUC Recommendation: 12.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,996

2021 Work RVU: 9.29
2021 NF PE RVU: 14.18
2021 Fac PE RVU: 7.58

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28820 **Amputation, toe; metatarsophalangeal joint**

Global: 000 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,702

2021 Work RVU: 3.51
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 1.34

RUC Recommendation: 4.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28825 **Amputation, toe; interphalangeal joint**

Global: 000 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,013

2021 Work RVU: 3.41
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.30

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Application of Forearm Cast **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 16 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** April 2011 **2019 est Medicare Utilization:** 68,396

2021 Work RVU: 0.77
2021 NF PE RVU: 1.62
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29105 **Application of long arm splint (shoulder to hand)**

Global: 000 **Issue:** Application of Long Arm Splint **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACEP, ASSH **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,626

2021 Work RVU: 0.80
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29200 **Strapping; thorax**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,693

2021 Work RVU: 0.39
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29220 **Deleted from CPT**

Global: **Issue:** Strapping; low back **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT, no further action necessary

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

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 16,307

2021 Work RVU: 0.39
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29260 **Strapping; elbow or wrist**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 5,004

2021 Work RVU: 0.39
2021 NF PE RVU: 0.45
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29280 **Strapping; hand or finger**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 3,404

2021 Work RVU: 0.39
2021 NF PE RVU: 0.43
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29445 **Application of rigid total contact leg cast**

Global: 000 **Issue:** Application of Rigid Leg Cast **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, AHKNS, AOFAS, AOA, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 36,431

2021 Work RVU: 1.78
2021 NF PE RVU: 1.78
2021 Fac PE RVU: 0.94

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29520 **Strapping; hip**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,018

2021 Work RVU: 0.39
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29530 **Strapping; knee**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 27,045

2021 Work RVU: 0.39
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29540 **Strapping; ankle and/or foot**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 213,060

2021 Work RVU: 0.39
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

29550 **Strapping; toes**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 56,200

2021 Work RVU: 0.25
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29580 **Strapping; Unna boot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 265,752

2021 Work RVU: 0.55
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29581 **Application of multi-layer compression system; leg (below knee), including ankle and foot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 194,064

2021 Work RVU: 0.60
2021 NF PE RVU: 2.03
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29582 **Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29583 **Application of multi-layer compression system; upper arm and forearm**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

Status Report: CMS Requests and Relativity Assessment Issues

29584 **Application of multi-layer compression system; upper arm, forearm, hand, and fingers**

Global: 000 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,715

2021 Work RVU: 0.35
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.10

RUC Recommendation: Develop CPT Assistant Article **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29590 **Denis-Browne splint strapping**

Global: **Issue:** Dennis-Browne splint revision **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

29805 **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 698

2021 Work RVU: 6.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.74

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29822 **Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2008 **2019 est Medicare Utilization:** 9,153

2021 Work RVU: 7.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.61

RUC Recommendation: 7.03 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29823 **Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization over 30,000-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 45,349

2021 Work RVU: 7.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.03

RUC Recommendation: 7.98 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29824 **Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS

First Identified: February 2010 **2019 est Medicare Utilization:** 39,895

2021 Work RVU: 8.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: 8.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 78,655

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29827 **Arthroscopy, shoulder, surgical; with rotator cuff repair**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing/ Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 69,465

2021 Work RVU: 15.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.97

RUC Recommendation: 15.59. Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29828 **Arthroscopy, shoulder, surgical; biceps tenodesis**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 18,992

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.38

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 136

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 125

2021 Work RVU: 5.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.66

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 13 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 1,031

2021 Work RVU: 5.19
2021 NF PE RVU: 10.58
2021 Fac PE RVU: 5.85

RUC Recommendation: New PE non-facility inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**

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

Most Recent RUC Meeting: April 2008 **Tab:** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,173

2021 Work RVU: 14.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.84

RUC Recommendation: 14.14 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 4

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.79

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

30140 **Submucous resection inferior turbinate, partial or complete, any method** **Global:** 000 **Issue:** Resection of Inferior Turbinate **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 14 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 49,954

2021 Work RVU: 3.00
2021 NF PE RVU: 5.28
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,626

2021 Work RVU: 12.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 88,372

2021 Work RVU: 1.10
2021 NF PE RVU: 3.36
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

30903 **Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 48,496

2021 Work RVU: 1.54
2021 NF PE RVU: 5.49
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

30905 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 5,245

2021 Work RVU: 1.97
2021 NF PE RVU: 8.29
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

30906 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 800

2021 Work RVU: 2.45
2021 NF PE RVU: 8.13
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2010 **2019 est Medicare Utilization:** 660,545

2021 Work RVU: 1.10
2021 NF PE RVU: 4.54
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31237 **Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 137,754

2021 Work RVU: 2.60
2021 NF PE RVU: 4.56
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31238 **Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 29,505

2021 Work RVU: 2.74
2021 NF PE RVU: 4.25
2021 Fac PE RVU: 1.71

RUC Recommendation: 2.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31239 **Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy**

Global: 010 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,366

2021 Work RVU: 9.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.80

RUC Recommendation: 9.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31240 **Nasal/sinus endoscopy, surgical; with concha bullosa resection**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 6,458

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 2.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31241 **Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 470

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.78

RUC Recommendation: 8.51 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31253 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,502

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.26

RUC Recommendation: 9.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31254 **Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 13,255

2021 Work RVU: 4.27
2021 NF PE RVU: 8.03
2021 Fac PE RVU: 2.19

RUC Recommendation: 4.27 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31255 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 11,287

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.84

RUC Recommendation: 5.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31256 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 15,592

2021 Work RVU: 3.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.11 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31257 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 5,920

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.00 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31259 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.48 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31267 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 28,703

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.68 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31276 **Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 15,859

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 6.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31287 **Nasal/sinus endoscopy, surgical, with sphenoidotomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,280

2021 Work RVU: 3.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31288 **Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,121

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 28,533

2021 Work RVU: 2.70
2021 NF PE RVU: 52.30
2021 Fac PE RVU: 1.50

RUC Recommendation: 2.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,725

2021 Work RVU: 3.10
2021 NF PE RVU: 52.59
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 2,120

2021 Work RVU: 2.44
2021 NF PE RVU: 52.17
2021 Fac PE RVU: 1.38

RUC Recommendation: 2.44 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 19,499

2021 Work RVU: 4.50
2021 NF PE RVU: 99.88
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.50 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31500 **Intubation, endotracheal, emergency procedure**

Global: 000 **Issue:** Endotracheal Intubation **Screen:** CMS High Expenditure Procedural Codes2 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** ACEP, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 263,123

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.72

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2016

Status Report: CMS Requests and Relativity Assessment Issues

31551 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2

2021 Work RVU: 21.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.58

RUC Recommendation: 21.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31552 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 12

2021 Work RVU: 20.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.16

RUC Recommendation: 20.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31553 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.58

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31554 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.60

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope**

Global: 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 5,271

2021 Work RVU: 4.26
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.32

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

31575 **Laryngoscopy, flexible; diagnostic**

Global: 000 **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2010 **2019 est Medicare Utilization:** 658,434

2021 Work RVU: 0.94
2021 NF PE RVU: 2.69
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

Global: 000 **Issue:** Laryngoscopy **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2008 **2019 est Medicare Utilization:** 86,928

2021 Work RVU: 1.88
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.31

RUC Recommendation: 1.94

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

31580 **Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 21

2021 Work RVU: 14.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.35

RUC Recommendation: 14.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31582 **Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 17.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.83

RUC Recommendation: 20.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31587 **Laryngoplasty, cricoid split, without graft placement**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 15.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.87

RUC Recommendation: 15.27 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31588 **Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31591 **Laryngoplasty, medialization, unilateral**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,148

2021 Work RVU: 13.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.65

RUC Recommendation: 15.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31592 **Cricotracheal resection**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.15

RUC Recommendation: 25.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31600 **Tracheostomy, planned (separate procedure);**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 23,498

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.38

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31601 **Tracheostomy, planned (separate procedure); younger than 2 years**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 4

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.93

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31603 **Tracheostomy, emergency procedure; transtracheal**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 801

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31605 **Tracheostomy, emergency procedure; cricothyroid membrane**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 278

2021 Work RVU: 6.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.02

RUC Recommendation: 6.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31610 **Tracheostomy, fenestration procedure with skin flaps**

Global: 090 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 15 **Specialty Developing Recommendation:** AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,593

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.66

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.01

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

31620 **Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])**

Global: **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 52,315

2021 Work RVU: 2.53
2021 NF PE RVU: 4.51
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.78 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31623 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2016 **2019 est Medicare Utilization:** 26,278

2021 Work RVU: 2.63
2021 NF PE RVU: 5.36
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31624 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 118,565

2021 Work RVU: 2.63
2021 NF PE RVU: 4.74
2021 Fac PE RVU: 1.04

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2013 **2019 est Medicare Utilization:** 19,149

2021 Work RVU: 3.11
2021 NF PE RVU: 7.16
2021 Fac PE RVU: 1.17

RUC Recommendation: 3.36 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,173

2021 Work RVU: 3.91
2021 NF PE RVU: 21.01
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.16 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 32,291

2021 Work RVU: 3.55
2021 NF PE RVU: 7.37
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,745

2021 Work RVU: 3.75
2021 NF PE RVU: 9.78
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,890

2021 Work RVU: 1.03
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 1.32
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31645 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 35,233

2021 Work RVU: 2.88
2021 NF PE RVU: 4.90
2021 Fac PE RVU: 1.13

RUC Recommendation: 2.88 **Referred to CPT** May 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31646 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.09

RUC Recommendation: 2.78 **Referred to CPT** May 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

31652 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 25,507

2021 Work RVU: 4.46
2021 NF PE RVU: 32.45
2021 Fac PE RVU: 1.59

RUC Recommendation: 5.00 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31653 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 13,988

2021 Work RVU: 4.96
2021 NF PE RVU: 33.33
2021 Fac PE RVU: 1.74

RUC Recommendation: 5.50 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31654 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])**

Global: ZZZ **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,214

2021 Work RVU: 1.40
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.70 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32201 **Pneumonostomy; with percutaneous drainage of abscess or cyst**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32405 **Biopsy, lung or mediastinum, percutaneous needle**

Global: **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 70,068

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32408 **Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed**

Global: 000 **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 3.18
2021 NF PE RVU: 24.27
2021 Fac PE RVU: 1.00

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32420 **Pneumocentesis, puncture of lung for aspiration**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32421 **Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32422 **Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32440 **Removal of lung, pneumonectomy;**

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

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 247

2021 Work RVU: 27.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.36

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32480 **Removal of lung, other than pneumonectomy; single lobe (lobectomy)** **Global:** 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 4,630

2021 Work RVU: 25.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32482 **Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)** **Global:** 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 294

2021 Work RVU: 27.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.58

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32491 **Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed** **Global:** 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 15

2021 Work RVU: 25.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.02

RUC Recommendation: Request further information from CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32551 **Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)**

Global: 000 **Issue:** Chest Tube Thoracostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,044

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.01

RUC Recommendation: 3.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32554 **Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,649

2021 Work RVU: 1.82
2021 NF PE RVU: 5.07
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.82 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 **Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 229,865

2021 Work RVU: 2.27
2021 NF PE RVU: 7.14
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.27 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32556 **Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,833

2021 Work RVU: 2.50
2021 NF PE RVU: 19.31
2021 Fac PE RVU: 0.80

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32557 **Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 38,244

2021 Work RVU: 3.12
2021 NF PE RVU: 16.44
2021 Fac PE RVU: 0.98

RUC Recommendation: 3.62 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32663 **Thoracoscopy, surgical; with lobectomy (single lobe)**

Global: 090 **Issue:** RAW review **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** STS **First Identified:** October 2008 **2019 est Medicare Utilization:** 9,229

2021 Work RVU: 24.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

33010 **Pericardiocentesis; initial**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,698

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33011 **Pericardiocentesis; subsequent**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 87

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33015 **Tube pericardiostomy**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,147

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33016 **Pericardiocentesis, including imaging guidance, when performed**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33017 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.60

RUC Recommendation: 5.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33018 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33019 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33020 **Pericardiotomy for removal of clot or foreign body (primary procedure)**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2018 **2019 est Medicare Utilization:** 122

2021 Work RVU: 14.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: 14.31 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33025 **Creation of pericardial window or partial resection for drainage**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2017 **2019 est Medicare Utilization:** 4,535

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.29

RUC Recommendation: 13.20 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33207 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,733

2021 Work RVU: 7.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 8.05 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33208 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 103,628

2021 Work RVU: 8.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.88

RUC Recommendation: 8.77 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33212 **Insertion of pacemaker pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 317

2021 Work RVU: 5.01
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 5.26 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33213 **Insertion of pacemaker pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 5.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 5.53 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33221 **Insertion of pacemaker pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 268

2021 Work RVU: 5.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.87

RUC Recommendation: 5.80 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33227 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,452

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.56

RUC Recommendation: 5.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,395

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.68

RUC Recommendation: 5.77 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,526

2021 Work RVU: 5.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.96

RUC Recommendation: 6.04 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33230 **Insertion of implantable defibrillator pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 140

2021 Work RVU: 6.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.86

RUC Recommendation: 6.32 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33231 **Insertion of implantable defibrillator pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

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

First Identified: April 2011

2019 est Medicare Utilization: 121

2021 Work RVU: 6.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 6.59

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

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

First Identified: February 2010

2019 est Medicare Utilization: 8,743

2021 Work RVU: 3.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.01

RUC Recommendation: 3.39

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

33240 **Insertion of implantable defibrillator pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

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

First Identified: February 2010

2019 est Medicare Utilization: 217

2021 Work RVU: 5.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.64

RUC Recommendation: 6.06

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

33241 **Removal of implantable defibrillator pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,043

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.61

RUC Recommendation: 3.29 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33249 **Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 42,661

2021 Work RVU: 14.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.73

RUC Recommendation: 15.17 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33262 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,000

2021 Work RVU: 5.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.90

RUC Recommendation: 6.06 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33263 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

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

First Identified: April 2011

2019 est Medicare Utilization: 7,980

2021 Work RVU: 6.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.01

RUC Recommendation: 6.33

Referred to CPT February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33264 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

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

First Identified: April 2011

2019 est Medicare Utilization: 11,831

2021 Work RVU: 6.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.17

RUC Recommendation: 6.60

Referred to CPT February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33282 **Implantation of patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.50

Referred to CPT February 2017

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33284 **Removal of an implantable, patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.00 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33405 **Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 17,344

2021 Work RVU: 41.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.58

RUC Recommendation: 41.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33430 **Replacement, mitral valve, with cardiopulmonary bypass**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: February 2008 **2019 est Medicare Utilization:** 7,658

2021 Work RVU: 50.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.29

RUC Recommendation: 50.93 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33533 **Coronary artery bypass, using arterial graft(s); single arterial graft**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 60,180

2021 Work RVU: 33.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.23

RUC Recommendation: 34.98 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33620 **Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:** 56

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33621 **Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 16.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

Status Report: CMS Requests and Relativity Assessment Issues

33622 **Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS **First Identified:** January 2015 **2019 est Medicare Utilization:** 1

2021 Work RVU: 64.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.49

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33741 **Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.98

RUC Recommendation: 14.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33745 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 20.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.24

RUC Recommendation: 20.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33746 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.88

RUC Recommendation: 10.50 **Referred to CPT** September 2019 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33863 **Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)**

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,812

2021 Work RVU: 58.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.72

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

33945 **Heart transplant, with or without recipient cardiectomy**

Global: 090 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 667

2021 Work RVU: 89.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 31.88

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33946 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2014 **2019 est Medicare Utilization:** 603

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33947 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 6.63 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33948 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33949 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 5,342

2021 Work RVU: 4.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 4.60 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33951 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33952 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,439

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 8.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33953 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.63

RUC Recommendation: 9.83 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33954 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 354

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33956 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 352

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.73

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33957 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33958 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 72

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.05 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33959 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.69 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33960 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33961 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33962 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 20

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33963 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 9.00 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33964 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 22

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33965 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 3.51 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33966 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 383

2021 Work RVU: 4.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33969 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.56

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33984 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 543

2021 Work RVU: 5.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.58

RUC Recommendation: 6.38 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33985 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 1

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.85

RUC Recommendation: 9.89 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33986 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 221

2021 Work RVU: 10.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.99

RUC Recommendation: 10.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33987 **Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 41

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.08 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33988 **Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 40

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33989 **Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 14

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

34701 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 824

2021 Work RVU: 23.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 23.71 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34702 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 99

2021 Work RVU: 36.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.51

RUC Recommendation: 36.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34703 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,118

2021 Work RVU: 26.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.34

RUC Recommendation: 26.52 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34704 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 141

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.18

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34705 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 13,089

2021 Work RVU: 29.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.07

RUC Recommendation: 29.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34706 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 641

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.45

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34707 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 652

2021 Work RVU: 22.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.55

RUC Recommendation: 22.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34708 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 85

2021 Work RVU: 36.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 36.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 3,632

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 6.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34710 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,186

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.80

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34711 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 367

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.26

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34712 **Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.47

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34713 **Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 16,159

2021 Work RVU: 2.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34714 **Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 487

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34715 **Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.32

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34716 **Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 798

2021 Work RVU: 7.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 7.19 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34800 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34802 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34803 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34804 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34805 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34806 **Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34812 **Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 9,013

2021 Work RVU: 4.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.90

RUC Recommendation: 4.13 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34820 **Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 82

2021 Work RVU: 7.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34825 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34826 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34833 **Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 46

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.29

RUC Recommendation: 8.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34834 **Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 366

2021 Work RVU: 2.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.48

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34900 **Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35301 **Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision**

Global: 090 **Issue:** Thromboendarterectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 21 **Specialty Developing Recommendation:** SVS **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,904

2021 Work RVU: 21.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.69

RUC Recommendation: 21.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

35450 **Transluminal balloon angioplasty, open; renal or other visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35452 **Transluminal balloon angioplasty, open; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35454 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35456 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35458 **Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35459 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35460 **Transluminal balloon angioplasty, open; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35470 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Removed from CPT referral **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35473 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 **Transluminal balloon angioplasty, percutaneous; venous** **Global:** **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35492 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35493 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35701 **Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 823

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.08

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35702 **Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.38

RUC Recommendation: 7.12 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35703 **Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35721 **Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery** **Global:** **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 484

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35741 **Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 199

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35761 **Exploration (not followed by surgical repair), with or without lysis of artery; other vessels**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,616

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36000 **Introduction of needle or intracatheter, vein**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.07

RUC Recommendation: CMS consider a bundled status for this code **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36010 **Introduction of catheter, superior or inferior vena cava**

Global: XXX **Issue:** Introduction of Catheter **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,377

2021 Work RVU: 2.18
2021 NF PE RVU: 14.12
2021 Fac PE RVU: 0.62

RUC Recommendation: Remove from re-review. **Referred to CPT** February 2011 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36140 **Introduction of needle or intracatheter, upper or lower extremity artery**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 20,331

2021 Work RVU: 1.76
2021 NF PE RVU: 13.35
2021 Fac PE RVU: 0.49

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36145 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36215 **Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization greater than 30,000-Part2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,269

2021 Work RVU: 4.17
2021 NF PE RVU: 28.04
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36216 **Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 5.27
2021 NF PE RVU: 27.97
2021 Fac PE RVU: 1.66

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 4,059

2021 Work RVU: 6.29
2021 NF PE RVU: 49.17
2021 Fac PE RVU: 1.98

RUC Recommendation: 6.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36218 **Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Selective Catheter Placement **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.01
2021 NF PE RVU: 5.35
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36221 **Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,095

2021 Work RVU: 3.92
2021 NF PE RVU: 27.05
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.51 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36222 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 7,752

2021 Work RVU: 5.28
2021 NF PE RVU: 31.56
2021 Fac PE RVU: 1.77

RUC Recommendation: 6.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36223 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 29,312

2021 Work RVU: 5.75
2021 NF PE RVU: 42.78
2021 Fac PE RVU: 2.20

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36224 **Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,594

2021 Work RVU: 6.25
2021 NF PE RVU: 55.63
2021 Fac PE RVU: 2.68

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36225 **Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,267

2021 Work RVU: 5.75
2021 NF PE RVU: 40.17
2021 Fac PE RVU: 2.13

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36226 **Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 32,221

2021 Work RVU: 6.25
2021 NF PE RVU: 52.87
2021 Fac PE RVU: 2.61

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36227 **Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 13,979

2021 Work RVU: 2.09
2021 NF PE RVU: 4.66
2021 Fac PE RVU: 0.83

RUC Recommendation: 2.32 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36228 **Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,336

2021 Work RVU: 4.25
2021 NF PE RVU: 34.39
2021 Fac PE RVU: 1.71

RUC Recommendation: 4.25 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36245 **Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: XXX **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 22 **Specialty Developing Recommendation:** ACC, ACR, SIR, SCAI, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:** 40,259

2021 Work RVU: 4.65
2021 NF PE RVU: 34.72
2021 Fac PE RVU: 1.43

RUC Recommendation: 4.90 **Referred to CPT** February 2010 and February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36246 **Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,476

2021 Work RVU: 5.02
2021 NF PE RVU: 20.12
2021 Fac PE RVU: 1.35

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36247 **Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,061

2021 Work RVU: 6.04
2021 NF PE RVU: 38.48
2021 Fac PE RVU: 1.65

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,334

2021 Work RVU: 1.01
2021 NF PE RVU: 2.71
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36251 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 3,603

2021 Work RVU: 5.10
2021 NF PE RVU: 35.66
2021 Fac PE RVU: 1.51

RUC Recommendation: 5.45 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36252 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 8,044

2021 Work RVU: 6.74
2021 NF PE RVU: 36.70
2021 Fac PE RVU: 2.26

RUC Recommendation: 7.38 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36253 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 1,646

2021 Work RVU: 7.30
2021 NF PE RVU: 57.15
2021 Fac PE RVU: 2.15

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36254 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 162

2021 Work RVU: 7.90
2021 NF PE RVU: 54.59
2021 Fac PE RVU: 2.47

RUC Recommendation: 8.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36410 **Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)**

Global: XXX **Issue:** Venipunture **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 36 **Specialty Developing Recommendation:** ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 155,240

2021 Work RVU: 0.18
2021 NF PE RVU: 0.31
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36475 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 109,583

2021 Work RVU: 5.30
2021 NF PE RVU: 31.36
2021 Fac PE RVU: 1.73

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36476 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** October 2013 **2019 est Medicare Utilization:** 7,170

2021 Work RVU: 2.65
2021 NF PE RVU: 5.77
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36478 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,677

2021 Work RVU: 5.30
2021 NF PE RVU: 25.42
2021 Fac PE RVU: 1.76

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36479 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,461

2021 Work RVU: 2.65
2021 NF PE RVU: 6.26
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 697

2021 Work RVU: 6.73
2021 NF PE RVU: 49.03
2021 Fac PE RVU: 2.06

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

36511 **Therapeutic apheresis; for white blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 235

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36512 **Therapeutic apheresis; for red blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 2,896

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36513 **Therapeutic apheresis; for platelets**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 192

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.94

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

Status Report: CMS Requests and Relativity Assessment Issues

36514 **Therapeutic apheresis; for plasma pheresis**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 28,894

2021 Work RVU: 1.81
2021 NF PE RVU: 17.01
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.81. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36515 **Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion**

Global: **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

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

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 1.56
2021 NF PE RVU: 56.69
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.56. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

36522 **Photopheresis, extracorporeal** **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 8,303

2021 Work RVU: 1.75
2021 NF PE RVU: 48.78
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.75. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36555 **Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 26

2021 Work RVU: 1.93
2021 NF PE RVU: 3.70
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36556 **Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 409,595

2021 Work RVU: 1.75
2021 NF PE RVU: 4.60
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36568 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2016 **2019 est Medicare Utilization:** 3

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.34

RUC Recommendation: 2.11 **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36569 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2015 **2019 est Medicare Utilization:** 14,961

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.90. Review at RAW in October 2021. **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36572 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 25

2021 Work RVU: 1.82
2021 NF PE RVU: 11.35
2021 Fac PE RVU: 0.65

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36573 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 88,728

2021 Work RVU: 1.70
2021 NF PE RVU: 10.27
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36584 **Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016 **2019 est Medicare Utilization:** 4,270

2021 Work RVU: 1.20
2021 NF PE RVU: 9.21
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.47 **Referred to CPT** September 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36620 **Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA

First Identified: July 2015 **2019 est Medicare Utilization:** 581,132

2021 Work RVU: 1.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36818 **Arteriovenous anastomosis, open; by upper arm cephalic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 5,179

2021 Work RVU: 12.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.81

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36819 **Arteriovenous anastomosis, open; by upper arm basilic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 7,456

2021 Work RVU: 13.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.87

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 13.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.90

RUC Recommendation: 13.99 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36821 **Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 30,775

2021 Work RVU: 11.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.61

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36822 **Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,949

2021 Work RVU: 14.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.66

RUC Recommendation: 15.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36830 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 20,101

2021 Work RVU: 12.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36834 **Deleted from CPT**

Global: **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AVA, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36901 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 68,183

2021 Work RVU: 3.36
2021 NF PE RVU: 17.84
2021 Fac PE RVU: 1.05

RUC Recommendation: 3.36 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36902 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 199,617

2021 Work RVU: 4.83
2021 NF PE RVU: 33.47
2021 Fac PE RVU: 1.47

RUC Recommendation: 4.83 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36903 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,847

2021 Work RVU: 6.39
2021 NF PE RVU: 140.30
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.39 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36904 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,595

2021 Work RVU: 7.50
2021 NF PE RVU: 48.72
2021 Fac PE RVU: 2.16

RUC Recommendation: 7.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36905 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,205

2021 Work RVU: 9.00
2021 NF PE RVU: 63.02
2021 Fac PE RVU: 2.73

RUC Recommendation: 9.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36906 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,028

2021 Work RVU: 10.42
2021 NF PE RVU: 173.18
2021 Fac PE RVU: 3.02

RUC Recommendation: 10.42 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36907 **Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 67,888

2021 Work RVU: 3.00
2021 NF PE RVU: 16.34
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36908 **Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,376

2021 Work RVU: 4.25
2021 NF PE RVU: 49.50
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.25 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36909 **Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,424

2021 Work RVU: 4.12
2021 NF PE RVU: 57.02
2021 Fac PE RVU: 1.11

RUC Recommendation: 4.12 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 893

2021 Work RVU: 7.74
2021 NF PE RVU: 180.49
2021 Fac PE RVU: 2.36

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37191 **Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 25,555

2021 Work RVU: 4.46
2021 NF PE RVU: 63.97
2021 Fac PE RVU: 1.38

RUC Recommendation: 4.71 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37192 **Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 32

2021 Work RVU: 7.10
2021 NF PE RVU: 31.60
2021 Fac PE RVU: 1.20

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37193 **Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 7,478

2021 Work RVU: 7.10
2021 NF PE RVU: 39.56
2021 Fac PE RVU: 2.01

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37201 **Transcatheter therapy, infusion for thrombolysis other than coronary**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37203 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37204 **Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37205 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37206 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37207 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37208 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37209 **Exchange of a previously placed intravascular catheter during thrombolytic therapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37210 **Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37211 **Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,642

2021 Work RVU: 7.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37212 **Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,012

2021 Work RVU: 6.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.89

RUC Recommendation: 7.06 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37213 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37214 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,963

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.66

RUC Recommendation: 3.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,377

2021 Work RVU: 7.90
2021 NF PE RVU: 74.19
2021 Fac PE RVU: 2.01

RUC Recommendation: Refer to CPT. 8.15 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37221 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,798

2021 Work RVU: 9.75
2021 NF PE RVU: 96.83
2021 Fac PE RVU: 2.50

RUC Recommendation: Refer to CPT. 10.00 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37222 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,550

2021 Work RVU: 3.73
2021 NF PE RVU: 16.14
2021 Fac PE RVU: 0.84

RUC Recommendation: Refer to CPT. 3.73 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37223 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,293

2021 Work RVU: 4.25
2021 NF PE RVU: 44.04
2021 Fac PE RVU: 1.00

RUC Recommendation: Refer to CPT. 4.25 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,142

2021 Work RVU: 8.75
2021 NF PE RVU: 88.47
2021 Fac PE RVU: 2.29

RUC Recommendation: Refer to CPT. 9.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,496

2021 Work RVU: 11.75
2021 NF PE RVU: 299.74
2021 Fac PE RVU: 3.24

RUC Recommendation: Refer to CPT. **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 24,981

2021 Work RVU: 10.24
2021 NF PE RVU: 273.20
2021 Fac PE RVU: 2.63

RUC Recommendation: Refer to CPT. 10.49 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 23,176

2021 Work RVU: 14.25
2021 NF PE RVU: 385.21
2021 Fac PE RVU: 3.70

RUC Recommendation: Refer to CPT. 14.50 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,531

2021 Work RVU: 10.75
2021 NF PE RVU: 128.91
2021 Fac PE RVU: 2.71

RUC Recommendation: Refer to CPT. 11.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 39,373

2021 Work RVU: 13.80
2021 NF PE RVU: 299.25
2021 Fac PE RVU: 3.68

RUC Recommendation: Refer to CPT. 14.05 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37230 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,808

2021 Work RVU: 13.55
2021 NF PE RVU: 284.04
2021 Fac PE RVU: 3.81

RUC Recommendation: Refer to CPT. 13.80 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37231 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,320

2021 Work RVU: 14.75
2021 NF PE RVU: 386.13
2021 Fac PE RVU: 4.12

RUC Recommendation: Refer to CPT. 15.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,835

2021 Work RVU: 4.00
2021 NF PE RVU: 23.55
2021 Fac PE RVU: 1.01

RUC Recommendation: Refer to CPT. 4.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37233 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,241

2021 Work RVU: 6.50
2021 NF PE RVU: 27.13
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 6.50 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37234 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 343

2021 Work RVU: 5.50
2021 NF PE RVU: 111.73
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 5.50 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37235 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 100

2021 Work RVU: 7.80
2021 NF PE RVU: 116.61
2021 Fac PE RVU: 2.24

RUC Recommendation: Refer to CPT. 7.80 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37236 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 13,074

2021 Work RVU: 8.75
2021 NF PE RVU: 84.52
2021 Fac PE RVU: 2.32

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37237 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 1,497

2021 Work RVU: 4.25
2021 NF PE RVU: 43.32
2021 Fac PE RVU: 0.98

RUC Recommendation: 4.25 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37238 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 10,579

2021 Work RVU: 6.04
2021 NF PE RVU: 106.77
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.29 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37239 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 4,688

2021 Work RVU: 2.97
2021 NF PE RVU: 53.45
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.34 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37241 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,922

2021 Work RVU: 8.75
2021 NF PE RVU: 137.81
2021 Fac PE RVU: 2.50

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37242 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,635

2021 Work RVU: 9.80
2021 NF PE RVU: 220.06
2021 Fac PE RVU: 2.58

RUC Recommendation: 11.98 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37243 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,067

2021 Work RVU: 11.74
2021 NF PE RVU: 271.90
2021 Fac PE RVU: 3.36

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37244 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,731

2021 Work RVU: 13.75
2021 NF PE RVU: 198.34
2021 Fac PE RVU: 4.14

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37246 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,680

2021 Work RVU: 7.00
2021 NF PE RVU: 51.34
2021 Fac PE RVU: 1.87

RUC Recommendation: 7.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37247 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 760

2021 Work RVU: 3.50
2021 NF PE RVU: 14.34
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37248 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 15,577

2021 Work RVU: 6.00
2021 NF PE RVU: 37.31
2021 Fac PE RVU: 1.79

RUC Recommendation: 6.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37249 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 3,865

2021 Work RVU: 2.97
2021 NF PE RVU: 11.33
2021 Fac PE RVU: 0.76

RUC Recommendation: 2.97 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37250 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37251 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37252 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 60,377

2021 Work RVU: 1.80
2021 NF PE RVU: 30.84
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.80 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37253 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 91,408

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

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

First Identified: September 2007 **2019 est Medicare Utilization:** 14,539

2021 Work RVU: 3.05
2021 NF PE RVU: 5.75
2021 Fac PE RVU: 2.33

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

37619 **Ligation of inferior vena cava**

Global: 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACS, SVS

First Identified: February 2011 **2019 est Medicare Utilization:** 33

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.67

RUC Recommendation: 37.60

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

37620 **Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

37760 **Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 65

2021 Work RVU: 10.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.01

RUC Recommendation: 10.69 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

37761 **Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg**

Global: 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** April 2009 **2019 est Medicare Utilization:** 350

2021 Work RVU: 9.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.43

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

37765 **Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 14,709

2021 Work RVU: 4.80
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37766 **Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 11,253

2021 Work RVU: 6.00
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 2.42

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37785 **Ligation, division, and/or excision of varicose vein cluster(s), 1 leg** **Global:** 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 934

2021 Work RVU: 3.93
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.69

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

38220 **Diagnostic bone marrow; aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 7,044

2021 Work RVU: 1.20
2021 NF PE RVU: 3.57
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.20 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

38221 **Diagnostic bone marrow; biopsy(ies)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,465

2021 Work RVU: 1.28
2021 NF PE RVU: 3.37
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.28 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

38222 **Diagnostic bone marrow; biopsy(ies) and aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 120,998

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.44 **Referred to CPT** February 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38505 **Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)**

Global: 000 **Issue:** Needle Biopsy of Lymph Nodes **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 33,584

2021 Work RVU: 1.14
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38542 **Dissection, deep jugular node(s)**

Global: 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 571

2021 Work RVU: 7.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 7.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38570 **Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,714

2021 Work RVU: 8.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.18

RUC Recommendation: 9.34 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** CMS Fastest Growing / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,981

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38572 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** ACOG **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,251

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.67

RUC Recommendation: 15.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38792 **Injection procedure; radioactive tracer for identification of sentinel node**

Global: 000 **Issue:** Radioactive Tracer **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 33,143

2021 Work RVU: 0.65
2021 NF PE RVU: 1.72
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

39400 **Mediastinoscopy, includes biopsy(ies), when performed**

Global: **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

39401 **Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 535

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 5.44 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

39402 **Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,086

2021 Work RVU: 7.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.87

RUC Recommendation: 7.50 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 **Biopsy of lip**

Global: 000 **Issue:** Biopsy of Lip **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS, AAD **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,762

2021 Work RVU: 1.22
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40650 **Repair lip, full thickness; vermilion only**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 355

2021 Work RVU: 3.78
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 4.60

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2016

Status Report: CMS Requests and Relativity Assessment Issues

40800 **Drainage of abscess, cyst, hematoma, vestibule of mouth; simple**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:**

First Identified: January 2014

2019 est Medicare Utilization: 2,390

2021 Work RVU: 1.23
2021 NF PE RVU: 4.87
2021 Fac PE RVU: 2.19

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

40801 **Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated**

Global: 010 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APMA, AAOS

First Identified: September 2007

2019 est Medicare Utilization: 1,609

2021 Work RVU: 2.63
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 2.97

RUC Recommendation: Maintain. Reduced 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

40808 **Biopsy, vestibule of mouth**

Global: 010 **Issue:** Biopsy of Mouth Lesion **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAOHNS, AAOMS

First Identified: April 2017

2019 est Medicare Utilization: 10,517

2021 Work RVU: 1.05
2021 NF PE RVU: 3.81
2021 Fac PE RVU: 1.36

RUC Recommendation: 1.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

40812 **Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,703

2021 Work RVU: 2.37
2021 NF PE RVU: 5.96
2021 Fac PE RVU: 2.85

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40820 **Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,264

2021 Work RVU: 1.34
2021 NF PE RVU: 6.47
2021 Fac PE RVU: 3.54

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

41530 **Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session**

Global: 000 **Issue:** Submucosal ablation of tongue base **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** July 2014 **2019 est Medicare Utilization:** 350

2021 Work RVU: 3.50
2021 NF PE RVU: 25.25
2021 Fac PE RVU: 7.42

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)**

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

Most Recent RUC Meeting: April 2008 **Tab:** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 518

2021 Work RVU: 9.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.13

RUC Recommendation: 9.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,439

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.16

RUC Recommendation: 18.12 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,561

2021 Work RVU: 19.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.21

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42440 **Excision of submandibular (submaxillary) gland**

Global: 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,780

2021 Work RVU: 6.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.06

RUC Recommendation: 7.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43191 **Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,988

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43192 **Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 211

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43193 **Esophagoscopy, rigid, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 210

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43194 **Esophagoscopy, rigid, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 115

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.99 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43195 **Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 569

2021 Work RVU: 3.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43196 **Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 486

2021 Work RVU: 3.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

43197 **Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,136

2021 Work RVU: 1.52
2021 NF PE RVU: 4.07
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43198 **Esophagoscopy, flexible, transnasal; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 255

2021 Work RVU: 1.82
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.89 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43200 **Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,390

2021 Work RVU: 1.42
2021 NF PE RVU: 6.21
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.59 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43201 **Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 220

2021 Work RVU: 1.72
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.90 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43202 **Esophagoscopy, flexible, transoral; with biopsy, single or multiple** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,578

2021 Work RVU: 1.72
2021 NF PE RVU: 8.94
2021 Fac PE RVU: 1.05

RUC Recommendation: 1.89 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43204 **Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 13

2021 Work RVU: 2.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.89 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43205 **Esophagoscopy, flexible, transoral; with band ligation of esophageal varices** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 2.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 3.00 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43206 **Esophagoscopy, flexible, transoral; with optical endomicroscopy**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 21

2021 Work RVU: 2.29
2021 NF PE RVU: 6.52
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43211 **Esophagoscopy, flexible, transoral; with endoscopic mucosal resection**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 99

2021 Work RVU: 4.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43212 **Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 585

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.57

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43213 **Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 187

2021 Work RVU: 4.63
2021 NF PE RVU: 33.35
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43214 **Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 3.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43215 **Esophagoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 989

2021 Work RVU: 2.44
2021 NF PE RVU: 9.30
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.60 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43216 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 195

2021 Work RVU: 2.30
2021 NF PE RVU: 10.01
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43217 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 53

2021 Work RVU: 2.80
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 1.56

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43219 **Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent** **Global:** **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43220 **Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,069

2021 Work RVU: 2.00
2021 NF PE RVU: 27.96
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.10 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43226 **Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,841

2021 Work RVU: 2.24
2021 NF PE RVU: 8.98
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.34 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 **Esophagoscopy, flexible, transoral; with control of bleeding, any method** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 191

2021 Work RVU: 2.89
2021 NF PE RVU: 15.89
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.26 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43228 **Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43229 **Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,331

2021 Work RVU: 3.49
2021 NF PE RVU: 18.25
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.72 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43231 **Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 502

2021 Work RVU: 2.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.19 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43232 **Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 435

2021 Work RVU: 3.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.83 **Referred to CPT** May 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43233 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 4.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.45 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43234 **Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43235 **Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** EGD **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 323,621

2021 Work RVU: 2.09
2021 NF PE RVU: 6.59
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.26 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43236 **Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 16,281

2021 Work RVU: 2.39
2021 NF PE RVU: 9.43
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2009 and Jun 2010

43237 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,922

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.85 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43238 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,141

2021 Work RVU: 4.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.50 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43239 **Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** EGD with Biopsy **Screen:** MPC List / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,424,058

2021 Work RVU: 2.39
2021 NF PE RVU: 8.84
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43240 **Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 7.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: 7.25 **Referred to CPT** February 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43241 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,312

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.36

RUC Recommendation: 2.59 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43242 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,340

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43243 **Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 647

2021 Work RVU: 4.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.14

RUC Recommendation: 4.37 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43244 **Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,233

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.26

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43245 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,047

2021 Work RVU: 3.08
2021 NF PE RVU: 15.04
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.18 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 **Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,081

2021 Work RVU: 3.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 4.32 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43247 **Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,637

2021 Work RVU: 3.11
2021 NF PE RVU: 8.12
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.27 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43248 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 110,879

2021 Work RVU: 2.91
2021 NF PE RVU: 9.18
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.01 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43249 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 125,878

2021 Work RVU: 2.67
2021 NF PE RVU: 31.47
2021 Fac PE RVU: 1.49

RUC Recommendation: 2.77 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43250 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,775

2021 Work RVU: 2.97
2021 NF PE RVU: 10.44
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.07 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,888

2021 Work RVU: 3.47
2021 NF PE RVU: 11.28
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43253 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** February 2012 **2019 est Medicare Utilization:** 2,309

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43254 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,797

2021 Work RVU: 4.87
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.46

RUC Recommendation: 5.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43255 **Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 62,091

2021 Work RVU: 3.56
2021 NF PE RVU: 16.12
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.20 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43256 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 **Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 148

2021 Work RVU: 4.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43258 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43259 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 34,294

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.74 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43260 **Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,795

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.90

RUC Recommendation: 5.95 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43261 **Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 7,154

2021 Work RVU: 6.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.04

RUC Recommendation: 6.25 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43262 **Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 30,450

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.60 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43263 **Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 67

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 7.28 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43264 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 56,121

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.25

RUC Recommendation: 6.73 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43265 **Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,820

2021 Work RVU: 7.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.03 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43266 **Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,767

2021 Work RVU: 3.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 4.40 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct**

Global: **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43270 **Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,628

2021 Work RVU: 4.01
2021 NF PE RVU: 18.21
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.39 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43271 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43272 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 **Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)**

Global: ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,668

2021 Work RVU: 2.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.24 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43274 **Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 43,064

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.07

RUC Recommendation: 8.74 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43275 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,287

2021 Work RVU: 6.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 6.96 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43276 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 16,434

2021 Work RVU: 8.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.24

RUC Recommendation: 9.10 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43277 **Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 6,694

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 7.11 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43278 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 600

2021 Work RVU: 7.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 8.08 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43450 **Dilation of esophagus, by unguided sound or bougie, single or multiple passes**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,670

2021 Work RVU: 1.28
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43453 **Dilation of esophagus, over guide wire**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,698

2021 Work RVU: 1.41
2021 NF PE RVU: 25.10
2021 Fac PE RVU: 0.93

RUC Recommendation: 1.51 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43456 **Dilation of esophagus, by balloon or dilator, retrograde**

Global: **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43458 **Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia**

Global: **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43760 **Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance**

Global: **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** July 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43762 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 49,049

2021 Work RVU: 0.75
2021 NF PE RVU: 6.23
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.75. Flag for Re-review. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43763 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.41
2021 NF PE RVU: 9.02
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.41. Flag for Re-review.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44143 **Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)**

Global: 090 **Issue:** RAW **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 10,216

2021 Work RVU: 27.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.94

RUC Recommendation: 99214 visit appropriate. Remove from screen.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,383

2021 Work RVU: 22.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 9,951

2021 Work RVU: 31.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

44380 **Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,038

2021 Work RVU: 0.87
2021 NF PE RVU: 4.95
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44381 **Ileoscopy, through stoma; with transendoscopic balloon dilation**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 1.38
2021 NF PE RVU: 29.46
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.48 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44382 **Ileoscopy, through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy Ileoscopy Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,549

2021 Work RVU: 1.17
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.27 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44383 **Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44384 **Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 124

2021 Work RVU: 2.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.11 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,312

2021 Work RVU: 1.20
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44386 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,832

2021 Work RVU: 1.50
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.91

RUC Recommendation: 1.60 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,180

2021 Work RVU: 2.72
2021 NF PE RVU: 6.39
2021 Fac PE RVU: 1.45

RUC Recommendation: 2.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44389 **Colonoscopy through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,551

2021 Work RVU: 3.02
2021 NF PE RVU: 9.13
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.12 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

44390 **Colonoscopy through stoma; with removal of foreign body(s)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 18

2021 Work RVU: 3.74
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44391 **Colonoscopy through stoma; with control of bleeding, any method**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 4.12
2021 NF PE RVU: 15.88
2021 Fac PE RVU: 2.12

RUC Recommendation: 4.22 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 297

2021 Work RVU: 3.53
2021 NF PE RVU: 7.58
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.63 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44393 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44394 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,081

2021 Work RVU: 4.03
2021 NF PE RVU: 8.72
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44397 **Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44401 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.34
2021 NF PE RVU: 77.43
2021 Fac PE RVU: 2.24

RUC Recommendation: 4.44 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44402 **Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.40

RUC Recommendation: 4.96 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44403 **Colonoscopy through stoma; with endoscopic mucosal resection**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.75

RUC Recommendation: 5.81 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44404 **Colonoscopy through stoma; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 3.02
2021 NF PE RVU: 9.22
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44405 **Colonoscopy through stoma; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 57

2021 Work RVU: 3.23
2021 NF PE RVU: 13.75
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.33 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44406 **Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.13

RUC Recommendation: 4.41 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44407 **Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.51

RUC Recommendation: 5.06 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44408 **Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 4.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.24 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

44901 **Incision and drainage of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

44970 **Laparoscopy, surgical, appendectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2019 est Medicare Utilization:** 22,448

2021 Work RVU: 9.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.13

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

45170 **Deleted from CPT**

Global: **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 8.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.72

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45172 **Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,918

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.18

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45300 **Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Diagnostic Proctosigmoidoscopy - Rigid **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACS, ASCRS, SAGES **First Identified:** July 2016 **2019 est Medicare Utilization:** 23,267

2021 Work RVU: 0.80
2021 NF PE RVU: 2.99
2021 Fac PE RVU: 0.48

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 50,795

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45331 **Sigmoidoscopy, flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 36,318

2021 Work RVU: 1.14
2021 NF PE RVU: 7.50
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.14 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45332 **Sigmoidoscopy, flexible; with removal of foreign body(s)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 353

2021 Work RVU: 1.76
2021 NF PE RVU: 6.40
2021 Fac PE RVU: 1.07

RUC Recommendation: 1.85 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45333 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 734

2021 Work RVU: 1.55
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.65 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45334 **Sigmoidoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,411

2021 Work RVU: 2.00
2021 NF PE RVU: 13.83
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45335 **Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,141

2021 Work RVU: 1.04
2021 NF PE RVU: 7.61
2021 Fac PE RVU: 0.76

RUC Recommendation: 1.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45337 **Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,691

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.20 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,383

2021 Work RVU: 2.05
2021 NF PE RVU: 6.77
2021 Fac PE RVU: 1.20

RUC Recommendation: 2.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45339 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45340 **Sigmoidoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,316

2021 Work RVU: 1.25
2021 NF PE RVU: 12.98
2021 Fac PE RVU: 0.85

RUC Recommendation: 1.35 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 **Sigmoidoscopy, flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,713

2021 Work RVU: 2.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

45342 **Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 374

2021 Work RVU: 2.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.08 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45345 **Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45346 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,183

2021 Work RVU: 2.81
2021 NF PE RVU: 76.84
2021 Fac PE RVU: 1.54

RUC Recommendation: 2.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45347 **Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 637

2021 Work RVU: 2.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.98 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45349 **Sigmoidoscopy, flexible; with endoscopic mucosal resection**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 632

2021 Work RVU: 3.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.86

RUC Recommendation: 3.83 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45350 **Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 1.68
2021 NF PE RVU: 18.66
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45355 **Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple** **Global:** **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 **Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS High Expenditure Procedural Codes1 / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 345,987

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45379 **Colonoscopy, flexible; with removal of foreign body(s)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 930

2021 Work RVU: 4.28
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.37 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45380 **Colonoscopy, flexible; with biopsy, single or multiple** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,054,879

2021 Work RVU: 3.56
2021 NF PE RVU: 9.25
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.66 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45381 **Colonoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 82,892

2021 Work RVU: 3.56
2021 NF PE RVU: 9.36
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.67 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2010

45382 **Colonoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,121

2021 Work RVU: 4.66
2021 NF PE RVU: 16.07
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.76 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45383 **Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 77,739

2021 Work RVU: 4.07
2021 NF PE RVU: 10.23
2021 Fac PE RVU: 2.01

RUC Recommendation: 4.17 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45385 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List / Codes Reported Together 75%or More-Part4 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 971,282

2021 Work RVU: 4.57
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 2.31

RUC Recommendation: 4.57 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45386 **Colonoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,321

2021 Work RVU: 3.77
2021 NF PE RVU: 14.77
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.87 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45387 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)** **Global:** **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45388 **Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 26,744

2021 Work RVU: 4.88
2021 NF PE RVU: 79.44
2021 Fac PE RVU: 2.41

RUC Recommendation: 4.98 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45389 **Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 420

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 5.50 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45390 **Colonoscopy, flexible; with endoscopic mucosal resection** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 23,129

2021 Work RVU: 6.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 6.35 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45391 **Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 932

2021 Work RVU: 4.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.95 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45392 **Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 86

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.60 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45393 **Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,112

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.78 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45398 **Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,509

2021 Work RVU: 4.20
2021 NF PE RVU: 20.44
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.30 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

46020 **Placement of seton**

Global: 010 **Issue:** Placement/Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,325

2021 Work RVU: 3.00
2021 NF PE RVU: 4.92
2021 Fac PE RVU: 3.50

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

46030 **Removal of anal seton, other marker**

Global: 010 **Issue:** Placement/ Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** April 2020 **2019 est Medicare Utilization:** 339

2021 Work RVU: 1.26
2021 NF PE RVU: 3.09
2021 Fac PE RVU: 1.17

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 992

2021 Work RVU: 3.59
2021 NF PE RVU: 10.05
2021 Fac PE RVU: 5.72

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

46500 **Injection of sclerosing solution, hemorrhoids**

Global: 010 **Issue:** Hemorrhoid Injection **Screen:** 010-Day Global Post-Operative Visits / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACS, ASCRS (colon) **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,575

2021 Work RVU: 1.74
2021 NF PE RVU: 7.52
2021 Fac PE RVU: 3.53

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47011 **Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47135 **Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age**

Global: 090 **Issue:** Liver Allotransplantation **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,590

2021 Work RVU: 90.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 46.85

RUC Recommendation: 91.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47136 **Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age**

Global: **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47382 **Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency**

Global: 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 3,121

2021 Work RVU: 14.97
2021 NF PE RVU: 108.30
2021 Fac PE RVU: 5.04

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47490 **Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation**

Global: 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 12,075

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.55

RUC Recommendation: 4.76 **Referred to CPT** June 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

47500 **Injection procedure for percutaneous transhepatic cholangiography**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47505 **Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47510 **Introduction of percutaneous transhepatic catheter for biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47511 **Introduction of percutaneous transhepatic stent for internal and external biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47525 **Change of percutaneous biliary drainage catheter**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47530 **Revision and/or reinsertion of transhepatic tube**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47531 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 8,621

2021 Work RVU: 1.30
2021 NF PE RVU: 11.26
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.30 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47532 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 549

2021 Work RVU: 4.25
2021 NF PE RVU: 21.37
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.50 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47533 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 5.38
2021 NF PE RVU: 31.52
2021 Fac PE RVU: 1.79

RUC Recommendation: 5.63 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47534 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 4,467

2021 Work RVU: 7.60
2021 NF PE RVU: 33.18
2021 Fac PE RVU: 2.42

RUC Recommendation: 7.85 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47535 **Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 438

2021 Work RVU: 3.95
2021 NF PE RVU: 24.60
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.20 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47536 **Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 14,577

2021 Work RVU: 2.61
2021 NF PE RVU: 17.79
2021 Fac PE RVU: 0.96

RUC Recommendation: 2.86 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47537 **Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 1.84
2021 NF PE RVU: 12.71
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.85 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47538 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,025

2021 Work RVU: 4.75
2021 NF PE RVU: 120.85
2021 Fac PE RVU: 1.62

RUC Recommendation: 5.00 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47539 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 135

2021 Work RVU: 8.75
2021 NF PE RVU: 128.69
2021 Fac PE RVU: 2.55

RUC Recommendation: 9.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47540 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 223

2021 Work RVU: 9.03
2021 NF PE RVU: 131.53
2021 Fac PE RVU: 2.84

RUC Recommendation: 9.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47541 **Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 170

2021 Work RVU: 6.75
2021 NF PE RVU: 29.20
2021 Fac PE RVU: 2.22

RUC Recommendation: 7.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47542 **Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,346

2021 Work RVU: 2.85
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47543 **Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 692

2021 Work RVU: 3.00
2021 NF PE RVU: 9.70
2021 Fac PE RVU: 0.89

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47544 **Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 322

2021 Work RVU: 3.28
2021 NF PE RVU: 24.66
2021 Fac PE RVU: 0.93

RUC Recommendation: 3.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47560 **Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy**

Global: **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

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

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

47562 **Laparoscopy, surgical; cholecystectomy**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACS

First Identified: September 2011 **2019 est Medicare Utilization:** 100,881

2021 Work RVU: 10.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.54

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

47563 **Laparoscopy, surgical; cholecystectomy with cholangiography**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

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

First Identified: September 2011 **2019 est Medicare Utilization:** 38,983

2021 Work RVU: 11.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.04

RUC Recommendation: No further action. 12.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47600 **Cholecystectomy;**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,195

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.02

RUC Recommendation: 20.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47605 **Cholecystectomy; with cholangiography**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,408

2021 Work RVU: 18.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.45

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

48102 **Biopsy of pancreas, percutaneous needle**

Global: 010 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 960

2021 Work RVU: 4.70
2021 NF PE RVU: 10.86
2021 Fac PE RVU: 1.75

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

48511 **External drainage, pseudocyst of pancreas; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

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

First Identified: January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49021 **Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49041 **Drainage of subdiaphragmatic or subphrenic abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR

First Identified: January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49061 **Drainage of retroperitoneal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49080 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial**

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

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent**

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

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49082 **Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,210

2021 Work RVU: 1.24
2021 NF PE RVU: 5.06
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.35 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 **Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 265,269

2021 Work RVU: 2.00
2021 NF PE RVU: 6.90
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.00 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49084 **Peritoneal lavage, including imaging guidance, when performed** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,879

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.50 **Referred to CPT** June 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49405 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 4.00
2021 NF PE RVU: 22.98
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49406 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,397

2021 Work RVU: 4.00
2021 NF PE RVU: 22.99
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49407 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 243

2021 Work RVU: 4.25
2021 NF PE RVU: 18.03
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49418 **Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,497

2021 Work RVU: 3.96
2021 NF PE RVU: 29.31
2021 Fac PE RVU: 1.50

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 **Deleted from CPT**

Global: **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49421 **Insertion of tunneled intraperitoneal catheter for dialysis, open**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,848

2021 Work RVU: 4.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.53

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49422 **Removal of tunneled intraperitoneal catheter**

Global: 000 **Issue:** Removal of Intraperitoneal Catheter **Screen:** Site of Service Anomaly - 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACS, SVS

First Identified: October 2016

2019 est Medicare Utilization: 12,368

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 4.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

49505 **Repair initial inguinal hernia, age 5 years or older; reducible**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACS

First Identified: September 2011

2019 est Medicare Utilization: 50,710

2021 Work RVU: 7.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.60

RUC Recommendation: Reaffirmed

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated**

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

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 10,329

2021 Work RVU: 9.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.12

RUC Recommendation: 10.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated**

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

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 1,809

2021 Work RVU: 11.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.00

RUC Recommendation: 12.44

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

49560 **Repair initial incisional or ventral hernia; reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 22,089

2021 Work RVU: 11.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.11

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49561 **Repair initial incisional or ventral hernia; incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 12,726

2021 Work RVU: 15.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.45

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49565 **Repair recurrent incisional or ventral hernia; reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,211

2021 Work RVU: 12.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.46

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49566 **Repair recurrent incisional or ventral hernia; incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 3,748

2021 Work RVU: 15.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.51

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49568 **Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)**

Global: ZZZ **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 27,767

2021 Work RVU: 4.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49570 **Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 616

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.93

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49572 **Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 451

2021 Work RVU: 7.87
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.60

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49580 **Repair umbilical hernia, younger than age 5 years; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** **2021 Work RVU:** 4.47 **2021 NF PE RVU:** NA **2021 Fac PE RVU:** 4.42

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49582 **Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 0 **2021 Work RVU:** 7.13 **2021 NF PE RVU:** NA **2021 Fac PE RVU:** 5.50

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49585 **Repair umbilical hernia, age 5 years or older; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 18,847 **2021 Work RVU:** 6.59 **2021 NF PE RVU:** NA **2021 Fac PE RVU:** 5.10

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,947 **2021 Work RVU:** 7.08 **2021 NF PE RVU:** NA **2021 Fac PE RVU:** 5.37

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49590 **Repair spigelian hernia** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 714

2021 Work RVU: 8.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.98

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 9,327

2021 Work RVU: 11.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.26

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 5,848

2021 Work RVU: 14.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.02

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,253

2021 Work RVU: 13.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.95

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49655 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 4,804

2021 Work RVU: 16.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49656 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 1,697

2021 Work RVU: 15.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.43

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49657 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 1,503

2021 Work RVU: 22.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49X01

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6.27 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X02

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 9.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X03

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 10.80 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X04

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 14.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X05

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 14.88 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X06

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 20.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X07

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 7.75 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X08

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 10.79 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X09

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 12.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X10

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 16.50 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X11

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 16.97 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X12

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 24.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X13

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 14.24 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X14

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 18.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X15

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 5.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

50021 **Drainage of perirenal or renal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** October 2019 **2019 est Medicare Utilization:** 2,659

2021 Work RVU: 15.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.75

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50081 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,937

2021 Work RVU: 23.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.97

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50200 **Renal biopsy; percutaneous, by trocar or needle**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 38,395

2021 Work RVU: 2.38
2021 NF PE RVU: 13.71
2021 Fac PE RVU: 1.10

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50360 **Renal allotransplantation, implantation of graft; without recipient nephrectomy** **Global:** 090 **Issue:** Renal Allotransplantation **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2012 **2019 est Medicare Utilization:** 12,479

2021 Work RVU: 39.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.26

RUC Recommendation: 40.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50387 **Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation** **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,721

2021 Work RVU: 1.75
2021 NF PE RVU: 15.40
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50392 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous** **Global:** **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50393 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50394 **Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50395 **Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous**

Global: **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50398 **Change of nephrostomy or pyelostomy tube**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50430 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 2.90
2021 NF PE RVU: 15.41
2021 Fac PE RVU: 1.28

RUC Recommendation: 3.15 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50431 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,818

2021 Work RVU: 1.10
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.42 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50432 **Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 28,285

2021 Work RVU: 4.00
2021 NF PE RVU: 23.39
2021 Fac PE RVU: 1.57

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50433 **Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 5,572

2021 Work RVU: 5.05
2021 NF PE RVU: 29.70
2021 Fac PE RVU: 1.85

RUC Recommendation: 5.05 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50434 **Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,477

2021 Work RVU: 3.75
2021 NF PE RVU: 24.12
2021 Fac PE RVU: 1.45

RUC Recommendation: 4.20 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50435 **Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,684

2021 Work RVU: 1.82
2021 NF PE RVU: 16.19
2021 Fac PE RVU: 0.89

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50436 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 607

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.31

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

50437 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 4.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

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

First Identified: October 2008 **2019 est Medicare Utilization:** 197

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.11

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

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

First Identified: October 2008 **2019 est Medicare Utilization:** 2,422

2021 Work RVU: 25.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.78

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50590 **Lithotripsy, extracorporeal shock wave**

Global: 090 **Issue:** Lithotripsy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 42 **Specialty Developing Recommendation:** AUA

First Identified: September 2011 **2019 est Medicare Utilization:** 54,658

2021 Work RVU: 9.77
2021 NF PE RVU: 11.03
2021 Fac PE RVU: 5.72

RUC Recommendation: 9.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

50605 **Ureterotomy for insertion of indwelling stent, all types**

Global: 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AUA, SIR

First Identified: October 2008 **2019 est Medicare Utilization:** 3,602

2021 Work RVU: 16.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.05

RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

50606 **Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 104

2021 Work RVU: 3.16
2021 NF PE RVU: 13.99
2021 Fac PE RVU: 0.91

RUC Recommendation: 3.16 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50693 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,504

2021 Work RVU: 3.96
2021 NF PE RVU: 27.17
2021 Fac PE RVU: 1.58

RUC Recommendation: 4.60 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50694 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 981

2021 Work RVU: 5.25
2021 NF PE RVU: 29.30
2021 Fac PE RVU: 1.99

RUC Recommendation: 6.00 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50695 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,321

2021 Work RVU: 6.80
2021 NF PE RVU: 34.84
2021 Fac PE RVU: 2.52

RUC Recommendation: 7.55 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50705 **Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.03
2021 NF PE RVU: 53.59
2021 Fac PE RVU: 0.65

RUC Recommendation: 4.03 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50706 **Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,459

2021 Work RVU: 3.80
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51040 **Cystostomy, cystotomy with drainage**

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

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

First Identified: September 2007 **2019 est Medicare Utilization:** 5,029

2021 Work RVU: 4.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

51102 **Aspiration of bladder; with insertion of suprapubic catheter**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 14,265

2021 Work RVU: 2.70
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51700 **Bladder irrigation, simple, lavage and/or instillation**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 194,801

2021 Work RVU: 0.60
2021 NF PE RVU: 1.63
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51701 **Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 168,108

2021 Work RVU: 0.50
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

51702 **Insertion of temporary indwelling bladder catheter; simple (eg, Foley)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 234,004

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51703 **Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 54,647

2021 Work RVU: 1.47
2021 NF PE RVU: 2.73
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51720 **Bladder instillation of anticarcinogenic agent (including retention time)**

Global: 000 **Issue:** Treatment of Bladder Lesion **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 33 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 160,447

2021 Work RVU: 0.87
2021 NF PE RVU: 1.64
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51726 **Complex cystometrogram (ie, calibrated electronic equipment);**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 1.71
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.71 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2021 Work RVU: 2.11
2021 NF PE RVU: 8.52
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 85,150

2021 Work RVU: 2.11
2021 NF PE RVU: 8.65
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,880

2021 Work RVU: 2.51
2021 NF PE RVU: 8.84
2021 Fac PE RVU: NA

RUC Recommendation: 2.51 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51736 **Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,797

2021 Work RVU: 0.17
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 **Complex uroflowmetry (eg, calibrated electronic equipment)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 423,494

2021 Work RVU: 0.17
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51772 **Deleted from CPT** **Global:** **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51784 **Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique**

Global: XXX **Issue:** Electromyography Studies (EMG) **Screen:** Codes Reported Together 75% or More-Part2 / CMS High Expenditure Procedural Codes2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 142,000

2021 Work RVU: 0.75
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. Maintain, CPT Assistant addressed issues identified.

Referred to CPT February 2014 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51792 **Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)**

Global: 000 **Issue:** Urinary Reflex Studies with EMG **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,152

2021 Work RVU: 1.10
2021 NF PE RVU: 6.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT edits and CPT Assistant article complete.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51795 **Deleted from CPT**

Global: **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51797 **Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

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

First Identified: February 2008

2019 est Medicare Utilization: 116,064

2021 Work RVU: 0.80
2021 NF PE RVU: 4.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51798 **Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging**

Global: XXX **Issue:** Voiding Pressure Studies **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 25 **Specialty Developing Recommendation:** AUA

First Identified: July 2015

2019 est Medicare Utilization: 2,169,510

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

52000 **Cystourethroscopy (separate procedure)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 35 **Specialty Developing Recommendation:** AUA, ACOG

First Identified: October 2010

2019 est Medicare Utilization: 897,375

2021 Work RVU: 1.53
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.63

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52214 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 16,853

2021 Work RVU: 3.50
2021 NF PE RVU: 19.06
2021 Fac PE RVU: 1.20

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52224 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 36,291

2021 Work RVU: 4.05
2021 NF PE RVU: 19.41
2021 Fac PE RVU: 1.39

RUC Recommendation: 4.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52234 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,317

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

Status Report: CMS Requests and Relativity Assessment Issues

52235 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,411

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52240 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,956

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 8.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52281 **Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female**

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

Most Recent RUC Meeting: April 2010 **Tab:** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 62,618

2021 Work RVU: 2.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52287 **Cystourethroscopy, with injection(s) for chemodenervation of the bladder** **Global:** 000 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 51,037

2021 Work RVU: 3.20
2021 NF PE RVU: 7.82
2021 Fac PE RVU: 1.32

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 **Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 151,015

2021 Work RVU: 2.82
2021 NF PE RVU: 9.94
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.82 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52334 **Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde** **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 289

2021 Work RVU: 3.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.54

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 2,487

2021 Work RVU: 5.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 191

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 21

2021 Work RVU: 6.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.65

RUC Recommendation: 6.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,393

2021 Work RVU: 7.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.82

RUC Recommendation: 7.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 480

2021 Work RVU: 7.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 212

2021 Work RVU: 8.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52351 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,929

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 5.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52352 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,811

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52353 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 11,180

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 7.50 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 9,144

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.49

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52356 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**

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

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** January 2013 **2019 est Medicare Utilization:** 78,507

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

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

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 115

2021 Work RVU: 8.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.19

RUC Recommendation: 8.69 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52442 **Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PE Subcommittee **Screen:** PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AUA, AACU **First Identified:** April 2020 **2019 est Medicare Utilization:** 101,717

2021 Work RVU: 1.01
2021 NF PE RVU: 28.12
2021 Fac PE RVU: 0.35

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,173

2021 Work RVU: 8.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.24

RUC Recommendation: 8.14 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52601 **Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)** **Global:** 090 **Issue:** Transurethral Electrosurgical Resection of Prostate (TURP) **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2015 **2019 est Medicare Utilization:** 44,942

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.56

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,396

2021 Work RVU: 4.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.98

RUC Recommendation: 4.79 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52648 **Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)**

Global: 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 18,059

2021 Work RVU: 12.15
2021 NF PE RVU: 36.73
2021 Fac PE RVU: 6.60

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**

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

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,071

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.55

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

53850 **Transurethral destruction of prostate tissue; by microwave thermotherapy**

Global: 090 **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 43 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,363

2021 Work RVU: 5.42
2021 NF PE RVU: 40.18
2021 Fac PE RVU: 4.25

RUC Recommendation: 10.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir**

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

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,217

2021 Work RVU: 14.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.40

RUC Recommendation: 14.39 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session**

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

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,286

2021 Work RVU: 15.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.22

RUC Recommendation: 15.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach**

Global: 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,671

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.61

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

54530 **Orchiectomy, radical, for tumor; inguinal approach**

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

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,190

2021 Work RVU: 8.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.37

RUC Recommendation: 8.46 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55700 **Biopsy, prostate; needle or punch, single or multiple, any approach**

Global: 000 **Issue:** Biopsy of Prostate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 36 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 156,362

2021 Work RVU: 2.50
2021 NF PE RVU: 4.57
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55706 **Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,297

2021 Work RVU: 6.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.95

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

55840 **Prostatectomy, retropubic radical, with or without nerve sparing;**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 1,610

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.22

RUC Recommendation: 21.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55842 **Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.24

RUC Recommendation: 24.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55845 **Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes**

Global: 090 **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,030

2021 Work RVU: 25.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: 29.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed**

Global: 090 **Issue:** Laparoscopic Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 27 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 20,334

2021 Work RVU: 26.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.05

RUC Recommendation: 26.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**

Global: 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,648

2021 Work RVU: 13.60
2021 NF PE RVU: 171.52
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.45 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55875 **Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy**

Global: 090 **Issue:** RAW **Screen:** RUC request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 6,399

2021 Work RVU: 13.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.66

RUC Recommendation: Review data at RAW

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Not Part of RAW

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)**

Global: 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

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

First Identified: September 2007

2019 est Medicare Utilization: 3,187

2021 Work RVU: 3.08
2021 NF PE RVU: 4.41
2021 Fac PE RVU: 2.65

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

56620 **Vulvectomy simple; partial**

Global: 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** D **Specialty Developing Recommendation:** ACOG

First Identified: September 2007

2019 est Medicare Utilization: 3,143

2021 Work RVU: 7.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.20

RUC Recommendation: 7.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

57150 **Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease**

Global: 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG

First Identified: July 2016

2019 est Medicare Utilization: 24,482

2021 Work RVU: 0.50
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

57155 **Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,111

2021 Work RVU: 5.15
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.64

RUC Recommendation: 5.40 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 **Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,369

2021 Work RVU: 2.69
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.69 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57160 **Fitting and insertion of pessary or other intravaginal support device** **Global:** 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 85,733

2021 Work RVU: 0.89
2021 NF PE RVU: 1.11
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.89 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57240 **Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2015 **2019 est Medicare Utilization:** 9,026

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.44

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57250 **Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,757

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57260 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 9,740

2021 Work RVU: 13.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.67

RUC Recommendation: 13.25 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,370

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.38

RUC Recommendation: 15.00 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57282 **Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 7,042

2021 Work RVU: 11.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.05

RUC Recommendation: 13.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57283 **Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,777

2021 Work RVU: 11.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.51 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 11.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.93

RUC Recommendation: 10.97 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 25,452

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.93

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57425 **Laparoscopy, surgical, colpopexy (suspension of vaginal apex)** **Global:** 090 **Issue:** Laparoscopic Colopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 27 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 9,468

2021 Work RVU: 17.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.10

RUC Recommendation: 18.02 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

58100 **Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)** **Global:** 000 **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 68,910

2021 Work RVU: 1.21
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58110 **Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2017 **2019 est Medicare Utilization:** 672

2021 Work RVU: 0.77
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58555 **Hysteroscopy, diagnostic (separate procedure)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 1,494

2021 Work RVU: 2.65
2021 NF PE RVU: 7.57
2021 Fac PE RVU: 1.38

RUC Recommendation: 3.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 47,694

2021 Work RVU: 4.17
2021 NF PE RVU: 38.05
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58559 **Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 121

2021 Work RVU: 5.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.35

RUC Recommendation: 5.54 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58560 **Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 44

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.55

RUC Recommendation: 6.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58561 **Hysteroscopy, surgical; with removal of leiomyomata**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,396

2021 Work RVU: 6.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.89

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.00
2021 NF PE RVU: 8.07
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 2,831

2021 Work RVU: 4.47
2021 NF PE RVU: 59.54
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 11.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.43

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)**

Global: 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 13,081

2021 Work RVU: 11.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.04

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58823 **Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,825

2021 Work RVU: 36.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.40

RUC Recommendation: 32.69 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,615

2021 Work RVU: 14.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.67

RUC Recommendation: 14.37 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 823

2021 Work RVU: 18.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: 18.54 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59412 **External cephalic version, with or without tocolysis**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 29

2021 Work RVU: 1.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 **Delivery of placenta (separate procedure)**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 1.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59425 **Antepartum care only; 4-6 visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 666

2021 Work RVU: 7.80
2021 NF PE RVU: 6.63
2021 Fac PE RVU: 3.05

RUC Recommendation: 6.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59426 **Antepartum care only; 7 or more visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 710

2021 Work RVU: 14.30
2021 NF PE RVU: 12.14
2021 Fac PE RVU: 5.62

RUC Recommendation: 11.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59430 **Postpartum care only (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 1,138

2021 Work RVU: 3.22
2021 NF PE RVU: 3.59
2021 Fac PE RVU: 1.26

RUC Recommendation: 2.47 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,365

2021 Work RVU: 40.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.09

RUC Recommendation: 36.17 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59514 **Cesarean delivery only;** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 16.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.25

RUC Recommendation: 16.13 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59515 **Cesarean delivery only; including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 760

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.19

RUC Recommendation: 22.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 89

2021 Work RVU: 38.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.53

RUC Recommendation: 34.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 65

2021 Work RVU: 16.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.14

RUC Recommendation: 16.09 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 20.06
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.11

RUC Recommendation: 20.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 22

2021 Work RVU: 40.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.17

RUC Recommendation: 36.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 13

2021 Work RVU: 16.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.36

RUC Recommendation: 16.66 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 6

2021 Work RVU: 22.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.81

RUC Recommendation: 22.53 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,841

2021 Work RVU: 11.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.47

RUC Recommendation: 12.29 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 308

2021 Work RVU: 14.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 14.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

60520 **Thymectomy, partial or total; transcervical approach (separate procedure)**

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

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 437

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

60521 **Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)**

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

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 254

2021 Work RVU: 19.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60522 **Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)**

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

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 120

2021 Work RVU: 23.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.24

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61055 **Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 293

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: Editorial change

Referred to CPT October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61781 **Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS

First Identified: October 2009 **2019 est Medicare Utilization:** 15,851

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.79

RUC Recommendation: 3.75

Referred to CPT October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61782 **Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,750

2021 Work RVU: 3.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 3.18 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61783 **Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,207

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.75 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61793 **Deleted from CPT**

Global: **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61795 **Deleted from CPT** **Global:** **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 6,704

2021 Work RVU: 13.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 8,122

2021 Work RVU: 3.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 3,528

2021 Work RVU: 19.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.63

RUC Recommendation: 19.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 570

2021 Work RVU: 4.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 4.81

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: February 2008

2019 est Medicare Utilization: 5,499

2021 Work RVU: 2.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 2.25

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS

First Identified: September 2007

2019 est Medicare Utilization: 5,787

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: 6.44

Referred to CPT October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 66 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 302

2021 Work RVU: 5.00
2021 NF PE RVU: 13.40
2021 Fac PE RVU: 3.59

RUC Recommendation: 6.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62270 **Spinal puncture, lumbar, diagnostic;**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 79,126

2021 Work RVU: 1.22
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

62272 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,301

2021 Work RVU: 1.58
2021 NF PE RVU: 3.31
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.80 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 390

2021 Work RVU: 2.66
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 1.76

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Q&A May 2010

62284 **Injection procedure for myelography and/or computed tomography, lumbar**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 16,213

2021 Work RVU: 1.54
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.54 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62287 **Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar**

Global: 090 **Issue:** Percutaneous Diskectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 166

2021 Work RVU: 9.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.85

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62290 **Injection procedure for discography, each level; lumbar**

Global: 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,115

2021 Work RVU: 3.00
2021 NF PE RVU: 7.65
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

62302 **Myelography via lumbar injection, including radiological supervision and interpretation; cervical**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,191

2021 Work RVU: 2.29
2021 NF PE RVU: 5.30
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62303 **Myelography via lumbar injection, including radiological supervision and interpretation; thoracic**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 411

2021 Work RVU: 2.29
2021 NF PE RVU: 5.43
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62304 **Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,417

2021 Work RVU: 2.25
2021 NF PE RVU: 5.25
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.25 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62305 **Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)**

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

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 6,616

2021 Work RVU: 2.35
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.35 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62310 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62311 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62318 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62319 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62320 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 5,631

2021 Work RVU: 1.80
2021 NF PE RVU: 2.89
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62321 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 217,240

2021 Work RVU: 1.95
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.00

RUC Recommendation: 1.95 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62322 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 42,693

2021 Work RVU: 1.55
2021 NF PE RVU: 2.55
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62323 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 699,990

2021 Work RVU: 1.80
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62324 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 19,559

2021 Work RVU: 1.89
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.89 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62325 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,225

2021 Work RVU: 2.20
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.20 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62326 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 4,644

2021 Work RVU: 1.78
2021 NF PE RVU: 2.31
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.78 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62327 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,995

2021 Work RVU: 1.90
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.90 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62328 **Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 5.71
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.95 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

62329 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.03
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.25 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,884

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62355 **Removal of previously implanted intrathecal or epidural catheter**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,056

2021 Work RVU: 3.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 4.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 242

2021 Work RVU: 4.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.12

RUC Recommendation: 4.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 5.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 5.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,146

2021 Work RVU: 5.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 3.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.88

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62367 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 10,982

2021 Work RVU: 0.48
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.19

RUC Recommendation: New PE inputs. 0.48 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62368 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 43,410

2021 Work RVU: 0.67
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.27

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62369 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 31,581

2021 Work RVU: 0.67
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62370 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 101,707

2021 Work RVU: 0.90
2021 NF PE RVU: 1.90
2021 Fac PE RVU: 0.36

RUC Recommendation: New PE inputs. 1.10 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63030 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis / Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,404

2021 Work RVU: 13.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.67

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63042 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,851

2021 Work RVU: 18.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.29

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63045 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:** **First Identified:** November 2013 **2019 est Medicare Utilization:** 10,977

2021 Work RVU: 17.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.22

RUC Recommendation: 17.95 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63046 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: November 2013 **2019 est Medicare Utilization:** 4,057

2021 Work RVU: 17.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.73

RUC Recommendation: 17.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63047 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar**

Global: 090 **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS

First Identified: September 2011 **2019 est Medicare Utilization:** 101,838

2021 Work RVU: 15.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.73

RUC Recommendation: 15.37 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63048 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS

First Identified: January 2012 **2019 est Medicare Utilization:** 128,927

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,048

2021 Work RVU: 21.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.52

RUC Recommendation: Review action plan at RAW Oct 2015. Maintain **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 428

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.62

RUC Recommendation: 19.60 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 313

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.99

RUC Recommendation: 4.04 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63090 **Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, AANS **First Identified:** January 2015 **2019 est Medicare Utilization:** 719

2021 Work RVU: 30.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.02

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 492

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.77

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 160

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.92

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63650 **Percutaneous implantation of neurostimulator electrode array, epidural** **Global:** 010 **Issue:** Percutaneous implantation of neurostimulator **Screen:** Site of Service Anomaly / CMS Fastest Growing / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 92,083

2021 Work RVU: 7.15
2021 NF PE RVU: 58.56
2021 Fac PE RVU: 4.24

RUC Recommendation: 7.20. New PE Inputs **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural** **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,801

2021 Work RVU: 10.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.29

RUC Recommendation: 11.43 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63660 **Deleted from CPT** **Global:** **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 3,832

2021 Work RVU: 5.08
2021 NF PE RVU: 14.23
2021 Fac PE RVU: 3.61

RUC Recommendation: 5.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 2,414

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 10.87 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 1,584

2021 Work RVU: 7.75
2021 NF PE RVU: 17.85
2021 Fac PE RVU: 4.47

RUC Recommendation: 70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 692

2021 Work RVU: 11.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.73

RUC Recommendation: 11.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 29,921

2021 Work RVU: 5.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.42

RUC Recommendation: Review action plan in 2 years after CPT article published. 6.05 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:**

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,593

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.54

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64405 **Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve** **Global:** 000 **Issue:** Injection - Greater Occipital Nerve **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 17 **Specialty Developing Recommendation:** AAN, AAPM, AAPMR, ASA **First Identified:** July 2016 **2019 est Medicare Utilization:** 134,871

2021 Work RVU: 0.94
2021 NF PE RVU: 1.04
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.94 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64412 **Injection, anesthetic agent; spinal accessory nerve** **Global:** **Issue:** Anesthetic Injection – Spinal Nerve **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 36 **Specialty Developing Recommendation:** AAN, ASA, AAPMR, ISIS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** FAQ Sept 2015

64415 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,150

2021 Work RVU: 1.35
2021 NF PE RVU: 1.89
2021 Fac PE RVU: 0.38

RUC Recommendation: Refer to CPT for bundling. 1.48 **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

Status Report: CMS Requests and Relativity Assessment Issues

64416 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA

First Identified: September 2007 **2019 est Medicare Utilization:** 17,912

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.27

RUC Recommendation: Refer to CPT for bundling. Remove from screen. 1.81

Referred to CPT May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64417 **Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**

Global: 000 **Issue:** Somatic Nerve Injection **Screen:** part of New/Revised Review **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA

First Identified: October 2018 **2019 est Medicare Utilization:** 15,765

2021 Work RVU: 1.27
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 0.39

RUC Recommendation: Refer to CPT

Referred to CPT May 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

64418 **Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve**

Global: 000 **Issue:** Injection, Anesthetic Agent **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA

First Identified: October 2015 **2019 est Medicare Utilization:** 31,818

2021 Work RVU: 1.10
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.10

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64445 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve** **Global:** 000 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 130,719

2021 Work RVU: 1.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64446 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 1.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT for bundling. 1.81 **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64447 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 282,703

2021 Work RVU: 1.10
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.35

RUC Recommendation: Refer to CPT for bundling. 1.50 **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

Status Report: CMS Requests and Relativity Assessment Issues

64448 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,188

2021 Work RVU: 1.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT for Bundling. Remove from screen. 1.63 **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64449 **Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,957

2021 Work RVU: 1.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.81 **Referred to CPT** February 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64450 **Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch**

Global: 000 **Issue:** Somatic Nerve Injection **Screen:** Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA, AAPM, APMA, ASIPP **First Identified:** October 2009 **2019 est Medicare Utilization:** 467,316

2021 Work RVU: 0.75
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2013

Status Report: CMS Requests and Relativity Assessment Issues

64455 **Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)**

Global: 000 **Issue:** Injection – Digital Nerves **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2016 **2019 est Medicare Utilization:** 74,450

2021 Work RVU: 0.75
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64461 **Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,096

2021 Work RVU: 1.75
2021 NF PE RVU: 2.05
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64462 **Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 1.10
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.24

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64463 **Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 1.90
2021 NF PE RVU: 4.59
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64470 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64472 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64475 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64476 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 44,367

2021 Work RVU: 2.29
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 1.32

RUC Recommendation: 2.29 **Referred to CPT** June 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

64480 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 19,219

2021 Work RVU: 1.20
2021 NF PE RVU: 2.66
2021 Fac PE RVU: 0.49

RUC Recommendation: 1.20 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,044,547

2021 Work RVU: 1.90
2021 NF PE RVU: 5.26
2021 Fac PE RVU: 1.18

RUC Recommendation: 1.90 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64484 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 431,178

2021 Work RVU: 1.00
2021 NF PE RVU: 2.19
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 265,103

2021 Work RVU: 1.82
2021 NF PE RVU: 3.71
2021 Fac PE RVU: 1.08

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 239,462

2021 Work RVU: 1.16
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 156,746

2021 Work RVU: 1.16
2021 NF PE RVU: 1.61
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 901,171

2021 Work RVU: 1.52
2021 NF PE RVU: 3.58
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 809,666

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 456,363

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 6,436

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 0.90

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 18,919

2021 Work RVU: 1.35
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 0.97

RUC Recommendation: PE Review - no change **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64550 **Application of surface (transcutaneous) neurostimulator (eg, TENS unit)** **Global:** **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AANS, CNS, AOTA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64553 **Percutaneous implantation of neurostimulator electrode array; cranial nerve** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** July 2014 **2019 est Medicare Utilization:** 484

2021 Work RVU: 6.13
2021 NF PE RVU: 64.69
2021 Fac PE RVU: 3.71

RUC Recommendation: 6.13 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

64555 **Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** High Volume Growth1 / CMS Fastest Growing / Final Rule for 2015 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,342

2021 Work RVU: 5.76
2021 NF PE RVU: 58.65
2021 Fac PE RVU: 3.42

RUC Recommendation: 5.76. Article published Jan2016 and addressed issues. **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** CMS Fastest Growing / High Volume Growth2 / High Level E/M in Global Period / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,987

2021 Work RVU: 5.44
2021 NF PE RVU: 16.70
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.44. 99214 visit appropriate. Remove from screen.

Referred to CPT September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64565 **Percutaneous implantation of neurostimulator electrode array; neuromuscular**

Global: **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64566 **Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming**

Global: 000 **Issue:** Posterior Tibial Neurostimulation **Screen:** CMS Request - Final Rule for 2014 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 201,680

2021 Work RVU: 0.60
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64568 **Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator**

Global: 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 11.19 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64573 **Deleted from CPT**

Global: **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64581 **Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 10,284

2021 Work RVU: 12.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.51

RUC Recommendation: 12.20. 99214 visit appropriate. Remove from screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64590 **Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** RAW **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 12,197

2021 Work RVU: 2.45
2021 NF PE RVU: 5.24
2021 Fac PE RVU: 1.92

RUC Recommendation: **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64615 **Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)**

Global: 010 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, NANS **First Identified:** October 2019 **2019 est Medicare Utilization:** 143,888

2021 Work RVU: 1.85
2021 NF PE RVU: 2.08
2021 Fac PE RVU: 1.18

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1/ CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64633 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 86,013

2021 Work RVU: 3.84
2021 NF PE RVU: 8.33
2021 Fac PE RVU: 2.35

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64634 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 135,589

2021 Work RVU: 1.32
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.32 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64635 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 358,450

2021 Work RVU: 3.78
2021 NF PE RVU: 8.28
2021 Fac PE RVU: 2.33

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

Status Report: CMS Requests and Relativity Assessment Issues

64636 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 539,040

2021 Work RVU: 1.16
2021 NF PE RVU: 3.89
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2015

64640 **Destruction by neurolytic agent; other peripheral nerve or branch**

Global: 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 25 **Specialty Developing Recommendation:** ASAM AAPM, APMA, ASIPP **First Identified:** September 2007 **2019 est Medicare Utilization:** 184,562

2021 Work RVU: 1.98
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 1.29

RUC Recommendation: 1.23. Remove 99238. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64708 **Neuroplasty, major peripheral nerve, arm or leg, open; other than specified**

Global: 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,356

2021 Work RVU: 6.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.44

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64712 **Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 705

2021 Work RVU: 8.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.85

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64831 **Suture of digital nerve, hand or foot; 1 nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 878

2021 Work RVU: 9.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 835

2021 Work RVU: 9.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.80

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

65205 **Removal of foreign body, external eye; conjunctival superficial** **Global:** 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 26,275

2021 Work RVU: 0.49
2021 NF PE RVU: 0.33
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65210 **Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating**

Global: 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA

First Identified: July 2016

2019 est Medicare Utilization: 25,202

2021 Work RVU: 0.61
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

65222 **Removal of foreign body, external eye; corneal, with slit lamp**

Global: 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 26 **Specialty Developing Recommendation:** AAO, AOA (optometric)

First Identified: April 2011

2019 est Medicare Utilization: 24,544

2021 Work RVU: 0.84
2021 NF PE RVU: 1.09
2021 Fac PE RVU: 0.58

RUC Recommendation: 0.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

Global: 090 **Issue:** Repair of Eye Wound **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 8 **Specialty Developing Recommendation:** AAO

First Identified: September 2007

2019 est Medicare Utilization: 704

2021 Work RVU: 15.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.46

RUC Recommendation: 16.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

65780 **Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

Global: 090 **Issue:** Ocular Reconstruction Transplant **Screen:** CMS Fastest Growing / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 31 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,974

2021 Work RVU: 7.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 8.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

65800 **Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,137

2021 Work RVU: 1.53
2021 NF PE RVU: 1.82
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.53 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 **Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous**

Global: **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65855 **Trabeculoplasty by laser surgery**

Global: 010 **Issue:** Trabeculoplasty by Laser Surgery **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 143,167

2021 Work RVU: 3.00
2021 NF PE RVU: 3.96
2021 Fac PE RVU: 2.71

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66170 **Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 6,957

2021 Work RVU: 13.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.61

RUC Recommendation: 13.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66172 **Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 3,104

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.54

RUC Recommendation: 14.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66174 **Transluminal dilation of aqueous outflow canal; without retention of device or stent**

Global: 090 **Issue:** Dilation of Aqueous Outflow Canal **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO

First Identified: April 2010 **2019 est Medicare Utilization:** 10,214

2021 Work RVU: 12.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.35

RUC Recommendation: 8.53 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66175 **Transluminal dilation of aqueous outflow canal; with retention of device or stent** **Global:** 090 **Issue:** Dilation of Aqueous Outflow Cana **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO **First Identified:** October 2020 **2019 est Medicare Utilization:** 223

2021 Work RVU: 13.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.88

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66179 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 802

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: 14.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66180 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 10,715

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.76

RUC Recommendation: Maintain. 15.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66183 **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,674

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.57

RUC Recommendation: Maintain. 13.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

66184 **Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 594

2021 Work RVU: 9.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.53

RUC Recommendation: 9.58 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66185 **Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,600

2021 Work RVU: 10.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.16

RUC Recommendation: Maintain. 10.58 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66711 **Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: October 2017 **2019 est Medicare Utilization:** 7,616

2021 Work RVU: 5.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.58

RUC Recommendation: 6.36 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)**

Global: 010 **Issue:** Iridotomy **Screen:** High IWPUT / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO

First Identified: February 2008 **2019 est Medicare Utilization:** 67,836

2021 Work RVU: 3.00
2021 NF PE RVU: 5.56
2021 Fac PE RVU: 3.60

RUC Recommendation: Maintain. 3.00 **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66821 **Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more**

Global: 090 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** AAO

First Identified: October 2010 **2019 est Medicare Utilization:** 685,933

2021 Work RVU: 3.42
2021 NF PE RVU: 6.06
2021 Fac PE RVU: 5.36

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66982 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 159,924

2021 Work RVU: 10.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.53

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

66983 **Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 93

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,694,951

2021 Work RVU: 7.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: 7.35 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66987 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 13.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66988 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

669X1

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 12.13 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

669X2

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 9.23 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)**

Global: 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 14 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,868,836

2021 Work RVU: 1.44
2021 NF PE RVU: 1.75
2021 Fac PE RVU: 1.11

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67036 **Vitrectomy, mechanical, pars plana approach;**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,016

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.84

RUC Recommendation: 12.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67038 **Deleted from CPT**

Global: **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

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

First Identified: September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2007 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 3,357

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.50

RUC Recommendation: 13.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 8,666

2021 Work RVU: 14.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.31

RUC Recommendation: 14.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67041 **Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,146

2021 Work RVU: 16.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67042 **Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 26,972

2021 Work RVU: 16.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67043 **Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 373

2021 Work RVU: 17.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.10

RUC Recommendation: 17.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67101 **Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 343

2021 Work RVU: 3.50
2021 NF PE RVU: 5.95
2021 Fac PE RVU: 4.45

RUC Recommendation: 3.50 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67105 **Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,778

2021 Work RVU: 3.39
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 4.29

RUC Recommendation: 3.84 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67107 **Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 623

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.23

RUC Recommendation: 16.00. Reduce 99238 to 0.5 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67108 **Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 16,523

2021 Work RVU: 17.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.93

RUC Recommendation: 17.13 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,305

2021 Work RVU: 10.25
2021 NF PE RVU: 14.89
2021 Fac PE RVU: 12.46

RUC Recommendation: 10.25. Remove 99238 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67112 **Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques**

Global: **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67113 **Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,384

2021 Work RVU: 19.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.96

RUC Recommendation: 19.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67141 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2020 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.15
2021 NF PE RVU: 8.63
2021 Fac PE RVU: 7.41

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67145 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 31,865

2021 Work RVU: 6.32
2021 NF PE RVU: 8.51
2021 Fac PE RVU: 7.52

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 56,884

2021 Work RVU: 6.36
2021 NF PE RVU: 8.14
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,636

2021 Work RVU: 6.36
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 168

2021 Work RVU: 0.47
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 **Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation**

Global: 010 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 62,152

2021 Work RVU: 4.39
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 4.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67255 **Scleral reinforcement (separate procedure); with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 833

2021 Work RVU: 8.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.83

RUC Recommendation: 10.17 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67311 **Strabismus surgery, recession or resection procedure; 1 horizontal muscle** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 4,955

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.90

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67312 **Strabismus surgery, recession or resection procedure; 2 horizontal muscles** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 9.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 9.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67314 **Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 2,533

2021 Work RVU: 8.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.32

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67316 **Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 168

2021 Work RVU: 10.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: 10.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67318 **Strabismus surgery, any procedure, superior oblique muscle**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 205

2021 Work RVU: 9.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.86

RUC Recommendation: 9.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67320 **Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 362

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.31

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67331 **Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 902

2021 Work RVU: 5.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67332 **Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,753

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.41

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67334 **Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 128

2021 Work RVU: 5.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 2.06 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67335 **Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,681

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

67340 **Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 88

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67500 **Retrobulbar injection; medication (separate procedure, does not include supply of medication)**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 1.18
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.52

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67505 **Retrobulbar injection; alcohol**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 140

2021 Work RVU: 1.18
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67515 **Injection of medication or other substance into Tenon's capsule**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** July 2016 **2019 est Medicare Utilization:** 24,360

2021 Work RVU: 0.75
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.56

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67820 **Correction of trichiasis; epilation, by forceps only**

Global: 000 **Issue:** Correction of Trichiasis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 29 **Specialty Developing Recommendation:** AOA, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 222,157

2021 Work RVU: 0.32
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67914 **Repair of ectropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,601

2021 Work RVU: 3.75
2021 NF PE RVU: 10.51
2021 Fac PE RVU: 5.40

RUC Recommendation: 3.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67915 **Repair of ectropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 332

2021 Work RVU: 2.03
2021 NF PE RVU: 7.26
2021 Fac PE RVU: 3.54

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67916 **Repair of ectropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,895

2021 Work RVU: 5.48
2021 NF PE RVU: 12.24
2021 Fac PE RVU: 6.46

RUC Recommendation: 5.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67917 **Repair of ectropion; extensive (eg, tarsal strip operations)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 24,678

2021 Work RVU: 5.93
2021 NF PE RVU: 12.07
2021 Fac PE RVU: 6.75

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67921 **Repair of entropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 3,614

2021 Work RVU: 3.47
2021 NF PE RVU: 10.56
2021 Fac PE RVU: 5.25

RUC Recommendation: 3.47

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67922 **Repair of entropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 100

2021 Work RVU: 2.03
2021 NF PE RVU: 6.95
2021 Fac PE RVU: 3.52

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67923 **Repair of entropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 1,300

2021 Work RVU: 5.48
2021 NF PE RVU: 12.25
2021 Fac PE RVU: 6.48

RUC Recommendation: 5.48

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67924 **Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 11,149

2021 Work RVU: 5.93
2021 NF PE RVU: 12.90
2021 Fac PE RVU: 6.76

RUC Recommendation: 5.93

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAO

First Identified: February 2008

2019 est Medicare Utilization: 6,702

2021 Work RVU: 0.85
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.49

RUC Recommendation: Revised parenthetical

Referred to CPT February 2013

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68200 **Subconjunctival injection**

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,059

2021 Work RVU: 0.49
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,980

2021 Work RVU: 0.82
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.39

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** Site of Service Anomaly / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2007 **2019 est Medicare Utilization:** 28,019

2021 Work RVU: 1.54
2021 NF PE RVU: 3.07
2021 Fac PE RVU: 2.02

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2014 **2019 est Medicare Utilization:** 451

2021 Work RVU: 1.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.01

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** January 2014 **2019 est Medicare Utilization:** 8,129

2021 Work RVU: 2.70
2021 NF PE RVU: 8.61
2021 Fac PE RVU: 3.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2014 **2019 est Medicare Utilization:** 248

2021 Work RVU: 2.10
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 2.26

RUC Recommendation: 2.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 **Biopsy external ear**

Global: 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 28 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 164,973

2021 Work RVU: 0.81
2021 NF PE RVU: 2.01
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69200 **Removal foreign body from external auditory canal; without general anesthesia** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2019 est Medicare Utilization:** 59,479

2021 Work RVU: 0.77
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 0.49

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69210 **Removal impacted cerumen requiring instrumentation, unilateral** **Global:** 000 **Issue:** Removal of Cerumen **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** AAFP, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,589,620

2021 Work RVU: 0.61
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.58. **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69400 **Eustachian tube inflation, transnasal; with catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69401 **Eustachian tube inflation, transnasal; without catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69405 **Eustachian tube catheterization, transtympanic**

Global: **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69433 **Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia**

Global: 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 30 **Specialty Developing Recommendation:** AAO-HNS

First Identified: April 2011 **2019 est Medicare Utilization:** 48,248

2021 Work RVU: 1.57
2021 NF PE RVU: 4.15
2021 Fac PE RVU: 2.03

RUC Recommendation: 1.57

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

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69801 **Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal**

Global: 000 **Issue:** Labyrinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 24,321

2021 Work RVU: 2.06
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 1.26

RUC Recommendation: Review action plan at RAW Oct 2015. 2.06

Referred to CPT Feb 2010 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

Status Report: CMS Requests and Relativity Assessment Issues

69802 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy** **Global:** **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Feburary 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69930 **Cochlear device implantation, with or without mastoidectomy** **Global:** 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** M **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,267

2021 Work RVU: 17.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.81

RUC Recommendation: 17.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70030 **Radiologic examination, eye, for detection of foreign body** **Global:** XXX **Issue:** X-Ray of Eye **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,756

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70100 **Radiologic examination, mandible; partial, less than 4 views** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,165

2021 Work RVU: 0.18
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70210 **Radiologic examination, sinuses, paranasal, less than 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 31,748

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70220 **Radiologic examination, sinuses, paranasal, complete, minimum of 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 59,212

2021 Work RVU: 0.22
2021 NF PE RVU: 0.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70250 **Radiologic examination, skull; less than 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 45,019

2021 Work RVU: 0.18
2021 NF PE RVU: 0.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70260 **Radiologic examination, skull; complete, minimum of 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 9,622

2021 Work RVU: 0.28
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70310 **Radiologic examination, teeth; partial examination, less than full mouth**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 0.16
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70360 **Radiologic examination; neck, soft tissue** **Global:** XXX **Issue:** X-Ray Exam – Neck **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 64,675

2021 Work RVU: 0.18
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70371 **Complex dynamic pharyngeal and speech evaluation by cine or video recording** **Global:** XXX **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,976

2021 Work RVU: 0.84
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published, addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

70373 **Laryngography, contrast, radiological supervision and interpretation** **Global:** **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

70450 **Computed tomography, head or brain; without contrast material**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,711,912

2021 Work RVU: 0.85
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70460 **Computed tomography, head or brain; with contrast material(s)**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 28,050

2021 Work RVU: 1.13
2021 NF PE RVU: 3.49
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70470 **Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,135

2021 Work RVU: 1.27
2021 NF PE RVU: 4.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70480 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 54,791

2021 Work RVU: 1.28
2021 NF PE RVU: 3.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70481 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 10,929

2021 Work RVU: 1.13
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70482 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,917

2021 Work RVU: 1.27
2021 NF PE RVU: 5.42
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70486 **Computed tomography, maxillofacial area; without contrast material**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 532,110

2021 Work RVU: 0.85
2021 NF PE RVU: 3.13
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70487 **Computed tomography, maxillofacial area; with contrast material(s)**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 30,559

2021 Work RVU: 1.13
2021 NF PE RVU: 3.62
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70488 **Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,505

2021 Work RVU: 1.27
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70490 **Computed tomography, soft tissue neck; without contrast material**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,230

2021 Work RVU: 1.28
2021 NF PE RVU: 3.38
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70491 **Computed tomography, soft tissue neck; with contrast material(s)**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 279,888

2021 Work RVU: 1.38
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70492 **Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 25,867

2021 Work RVU: 1.62
2021 NF PE RVU: 5.37
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 525,192

2021 Work RVU: 1.75
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 546,880

2021 Work RVU: 1.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70540 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 10,325

2021 Work RVU: 1.35
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70542 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 993

2021 Work RVU: 1.62
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70543 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,843

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70544 **Magnetic resonance angiography, head; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 247,119

2021 Work RVU: 1.20
2021 NF PE RVU: 5.71
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70545 **Magnetic resonance angiography, head; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 3,638

2021 Work RVU: 1.20
2021 NF PE RVU: 6.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70546 **Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 18,220

2021 Work RVU: 1.48
2021 NF PE RVU: 9.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70547 **Magnetic resonance angiography, neck; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 78,876

2021 Work RVU: 1.20
2021 NF PE RVU: 5.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70548 **Magnetic resonance angiography, neck; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,524

2021 Work RVU: 1.50
2021 NF PE RVU: 6.32
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70549 **Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 58,959

2021 Work RVU: 1.80
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70551 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,166,152

2021 Work RVU: 1.48
2021 NF PE RVU: 4.76
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70552 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,951

2021 Work RVU: 1.78
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70553 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,005,264

2021 Work RVU: 2.29
2021 NF PE RVU: 7.97
2021 Fac PE RVU: NA

RUC Recommendation: 2.36 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71010 **Radiologic examination, chest; single view, frontal**

Global: **Issue:** Chest X-Rays **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71015 **Radiologic examination, chest; stereo, frontal**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71020 **Radiologic examination, chest, 2 views, frontal and lateral;** **Global:** **Issue:** Chest X-Rays **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71021 **Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71022 **Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71023 **Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy** **Global:** **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71030 **Radiologic examination, chest, complete, minimum of 4 views;** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71034 **Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71035 **Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71045 **Radiologic examination, chest; single view**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,582,853

2021 Work RVU: 0.18
2021 NF PE RVU: 0.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71046 **Radiologic examination, chest; 2 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,465,557

2021 Work RVU: 0.22
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71047 **Radiologic examination, chest; 3 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,324

2021 Work RVU: 0.27
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71048 **Radiologic examination, chest; 4 or more views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,897

2021 Work RVU: 0.31
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: **Issue:** Insertion/Removal of Pacemeaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71100 **Radiologic examination, ribs, unilateral; 2 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 174,554

2021 Work RVU: 0.22
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71101 **Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 301,474

2021 Work RVU: 0.27
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71110 **Radiologic examination, ribs, bilateral; 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 24,795

2021 Work RVU: 0.29
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

71111 **Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 30,595

2021 Work RVU: 0.32
2021 NF PE RVU: 1.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.32

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

71250 **Computed tomography, thorax, diagnostic; without contrast material**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 2,320,224

2021 Work RVU: 1.08
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

71260 **Computed tomography, thorax, diagnostic; with contrast material(s)**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,835,534

2021 Work RVU: 1.16
2021 NF PE RVU: 4.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71270 **Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 70,977

2021 Work RVU: 1.25
2021 NF PE RVU: 4.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71271 **Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** **First Identified:** May 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.08
2021 NF PE RVU: 3.18
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** CT Angiography-Chest **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 27 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,282,747

2021 Work RVU: 1.82
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

72020 **Radiologic examination, spine, single view, specify level**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 145,820

2021 Work RVU: 0.16
2021 NF PE RVU: 0.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72040 **Radiologic examination, spine, cervical; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 641,468

2021 Work RVU: 0.22
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72050 **Radiologic examination, spine, cervical; 4 or 5 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 378,821

2021 Work RVU: 0.27
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72052 **Radiologic examination, spine, cervical; 6 or more views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 80,862

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72070 **Radiologic examination, spine; thoracic, 2 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 300,255

2021 Work RVU: 0.20
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72072 **Radiologic examination, spine; thoracic, 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 184,802

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72074 **Radiologic examination, spine; thoracic, minimum of 4 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 12,934

2021 Work RVU: 0.25
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72080 **Radiologic examination, spine; thoracolumbar junction, minimum of 2 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 46,745

2021 Work RVU: 0.21
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72100 **Radiologic examination, spine, lumbosacral; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,818,987

2021 Work RVU: 0.22
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72110 **Radiologic examination, spine, lumbosacral; minimum of 4 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 821,121

2021 Work RVU: 0.26
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

72114 **Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 96,261

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72120 **Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,798

2021 Work RVU: 0.22
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,308,607

2021 Work RVU: 1.00
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 20,553

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,798

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128 **Computed tomography, thoracic spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,533

2021 Work RVU: 1.00
2021 NF PE RVU: 3.03
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72129 **Computed tomography, thoracic spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 26,437

2021 Work RVU: 1.22
2021 NF PE RVU: 4.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,318

2021 Work RVU: 1.27
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72131 **Computed tomography, lumbar spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 519,043

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72132 **Computed tomography, lumbar spine; with contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,654

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,078

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** September 2011 **2019 est Medicare Utilization:** 600,156

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72142 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,391

2021 Work RVU: 1.78
2021 NF PE RVU: 7.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72146 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 223,500

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72147 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,124

2021 Work RVU: 1.78
2021 NF PE RVU: 7.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72148 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, AUR, ACR, NASS, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,346,832

2021 Work RVU: 1.48
2021 NF PE RVU: 4.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72149 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,622

2021 Work RVU: 1.78
2021 NF PE RVU: 6.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72156 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 120,879

2021 Work RVU: 2.29
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 2.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72157 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 98,889

2021 Work RVU: 2.29
2021 NF PE RVU: 8.09
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72158 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 244,364

2021 Work RVU: 2.29
2021 NF PE RVU: 8.05
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72170 **Radiologic examination, pelvis; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** Low Value-High Volume / Codes Reported Together 75% or More-Part2 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010

2019 est Medicare Utilization: 792,294

2021 Work RVU: 0.17
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.17

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72190 **Radiologic examination, pelvis; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 56,338

2021 Work RVU: 0.25
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,441

2021 Work RVU: 1.81
2021 NF PE RVU: 7.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.81 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72192 **Computed tomography, pelvis; without contrast material**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 183,953

2021 Work RVU: 1.09
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.09 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72193 **Computed tomography, pelvis; with contrast material(s)**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,206

2021 Work RVU: 1.16
2021 NF PE RVU: 6.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,552

2021 Work RVU: 1.22
2021 NF PE RVU: 6.81
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72195 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 85,947

2021 Work RVU: 1.46
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72196 **Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,606

2021 Work RVU: 1.73
2021 NF PE RVU: 7.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72197 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,192

2021 Work RVU: 2.20
2021 NF PE RVU: 8.83
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72200 **Radiologic examination, sacroiliac joints; less than 3 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 14,605

2021 Work RVU: 0.17
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72202 **Radiologic examination, sacroiliac joints; 3 or more views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 39,418

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72220 **Radiologic examination, sacrum and coccyx, minimum of 2 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: April 2016

2019 est Medicare Utilization: 116,528

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

72240 **Myelography, cervical, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012

2019 est Medicare Utilization: 647

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

72255 **Myelography, thoracic, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2013

2019 est Medicare Utilization: 125

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72265 **Myelography, lumbosacral, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,681

2021 Work RVU: 0.83
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72270 **Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,087

2021 Work RVU: 1.33
2021 NF PE RVU: 2.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.33 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72275 **Epidurography, radiological supervision and interpretation**

Global: XXX **Issue:** Epidurography **Screen:** Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 66,516

2021 Work RVU: 0.76
2021 NF PE RVU: 3.29
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009 and Q&A - May 2010

Status Report: CMS Requests and Relativity Assessment Issues

72291 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

72292 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73000 **Radiologic examination; clavicle, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 100,682

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73010 **Radiologic examination; scapula, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 51,052

2021 Work RVU: 0.17
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73020 **Radiologic examination, shoulder; 1 view**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 119,144

2021 Work RVU: 0.15
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73030 **Radiologic examination, shoulder; complete, minimum of 2 views**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** Low Value-High Volume / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2010 **2019 est Medicare Utilization:** 2,765,924

2021 Work RVU: 0.18
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73050 **Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 8,123

2021 Work RVU: 0.18
2021 NF PE RVU: 0.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73060 **Radiologic examination; humerus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 341,436

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73070 **Radiologic examination, elbow; 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 219,794

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73080 **Radiologic examination, elbow; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 404,093

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73090 **Radiologic examination; forearm, 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 230,897

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73100 **Radiologic examination, wrist; 2 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 274,134

2021 Work RVU: 0.16
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73110 **Radiologic examination, wrist; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,064,258

2021 Work RVU: 0.17
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73120 **Radiologic examination, hand; 2 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:** 278,753

2021 Work RVU: 0.16
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73130 **Radiologic examination, hand; minimum of 3 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,282,863

2021 Work RVU: 0.17
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73140 **Radiologic examination, finger(s), minimum of 2 views** **Global:** XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 388,288

2021 Work RVU: 0.13
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73200 **Computed tomography, upper extremity; without contrast material** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 23 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 126,320

2021 Work RVU: 1.00
2021 NF PE RVU: 4.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.09 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73201 **Computed tomography, upper extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,360

2021 Work RVU: 1.16
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2021 Work RVU: 1.22
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73206 **Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** May 2013 **2019 est Medicare Utilization:** 6,543

2021 Work RVU: 1.81
2021 NF PE RVU: 7.60
2021 Fac PE RVU: NA

RUC Recommendation: Survey with all CTA codes for October 2013.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 33,624

2021 Work RVU: 1.35
2021 NF PE RVU: 8.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2011

Result: Maintain

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 475,051

2021 Work RVU: 1.35
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73500 **Radiologic examination, hip, unilateral; 1 view**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73501 **Radiologic examination, hip, unilateral, with pelvis when performed; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 285,022

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73502 **Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,694,536

2021 Work RVU: 0.22
2021 NF PE RVU: 1.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73503 **Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,804

2021 Work RVU: 0.27
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73510 **Radiologic examination, hip, unilateral; complete, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73520 **Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73521 **Radiologic examination, hips, bilateral, with pelvis when performed; 2 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 158,149

2021 Work RVU: 0.22
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73522 **Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 188,143

2021 Work RVU: 0.29
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73523 **Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 107,476

2021 Work RVU: 0.31
2021 NF PE RVU: 1.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73540 **Radiologic examination, pelvis and hips, infant or child, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73542 **Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation**

Global: **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT

73550 **Radiologic examination, femur, 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73551 **Radiologic examination, femur; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 37,871

2021 Work RVU: 0.16
2021 NF PE RVU: 0.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73552 **Radiologic examination, femur; minimum 2 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 548,327

2021 Work RVU: 0.18
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73560 **Radiologic examination, knee; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,784,814

2021 Work RVU: 0.16
2021 NF PE RVU: 0.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73562 **Radiologic examination, knee; 3 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 2,516,006

2021 Work RVU: 0.18
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73564 **Radiologic examination, knee; complete, 4 or more views** **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,648,754

2021 Work RVU: 0.22
2021 NF PE RVU: 1.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73565 **Radiologic examination, knee; both knees, standing, anteroposterior** **Global:** XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 207,121

2021 Work RVU: 0.16
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 30,453

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: Survey and review CPT Assistant article in 2 years (Oct 2023) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

Status Report: CMS Requests and Relativity Assessment Issues

73590 **Radiologic examination; tibia and fibula, 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 500,593

2021 Work RVU: 0.16
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73600 **Radiologic examination, ankle; 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 240,693

2021 Work RVU: 0.16
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73610 **Radiologic examination, ankle; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,281,503

2021 Work RVU: 0.17
2021 NF PE RVU: 0.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73620 **Radiologic examination, foot; 2 views**

Global: XXX **Issue:** X-Ray Exam of Foot **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACR, AAOS, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 574,129

2021 Work RVU: 0.16
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73630 **Radiologic examination, foot; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,820,181

2021 Work RVU: 0.17
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73650 **Radiologic examination; calcaneus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Heel **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 81,836

2021 Work RVU: 0.16
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73660 **Radiologic examination; toe(s), minimum of 2 views**

Global: XXX **Issue:** X-Ray Toe **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 32 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 120,091

2021 Work RVU: 0.13
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73700 **Computed tomography, lower extremity; without contrast material**

Global: XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 338,278

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73701 **Computed tomography, lower extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 47,637

2021 Work RVU: 1.16
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,842

2021 Work RVU: 1.22
2021 NF PE RVU: 4.88
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Global:** XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 16,508

2021 Work RVU: 1.90
2021 NF PE RVU: 8.30
2021 Fac PE RVU: NA

RUC Recommendation: Survey for October 2013. Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73718 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 148,143

2021 Work RVU: 1.35
2021 NF PE RVU: 5.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73719 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,344

2021 Work RVU: 1.62
2021 NF PE RVU: 6.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73720 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 64,864

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73721 **Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material**

Global: XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 670,662

2021 Work RVU: 1.35
2021 NF PE RVU: 5.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74000 **Radiologic examination, abdomen; single anteroposterior view**

Global: **Issue:** Abdominal X-Ray **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74010 **Radiologic examination, abdomen; anteroposterior and additional oblique and cone views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74018 **Radiologic examination, abdomen; 1 view**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 2,153,087

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74019 **Radiologic examination, abdomen; 2 views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 429,437

2021 Work RVU: 0.23
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.23

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74020 **Radiologic examination, abdomen; complete, including decubitus and/or erect views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74021 **Radiologic examination, abdomen; 3 or more views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 58,811

2021 Work RVU: 0.27
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.27

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74022 **Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization: 283,318

2021 Work RVU: 0.32
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.32

Referred to CPT February 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74150 **Computed tomography, abdomen; without contrast material**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS Request - Final Rule for 2012 **Complete?** Yes

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

First Identified: February 2008

2019 est Medicare Utilization: 77,343

2021 Work RVU: 1.19
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74160 **Computed tomography, abdomen; with contrast material(s)**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / MPC List / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 105,409

2021 Work RVU: 1.27
2021 NF PE RVU: 6.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.42

Referred to CPT October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 34 **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 107,476

2021 Work RVU: 1.40
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.40

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified:

2019 est Medicare Utilization: 294,980

2021 Work RVU: 2.20
2021 NF PE RVU: 9.64
2021 Fac PE RVU: NA

RUC Recommendation: 2.20

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2008

2019 est Medicare Utilization: 37,638

2021 Work RVU: 1.82
2021 NF PE RVU: 7.68
2021 Fac PE RVU: NA

RUC Recommendation: 1.82

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

74176 **Computed tomography, abdomen and pelvis; without contrast material** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,284,436

2021 Work RVU: 1.74
2021 NF PE RVU: 3.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 **Computed tomography, abdomen and pelvis; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen and Pelvis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,361,910

2021 Work RVU: 1.82
2021 NF PE RVU: 7.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74178 **Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 534,971

2021 Work RVU: 2.01
2021 NF PE RVU: 8.78
2021 Fac PE RVU: NA

RUC Recommendation: 2.01 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74181 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 117,420

2021 Work RVU: 1.46
2021 NF PE RVU: 4.86
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74182 **Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 4,286

2021 Work RVU: 1.73
2021 NF PE RVU: 8.19
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74183 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 354,840

2021 Work RVU: 2.20
2021 NF PE RVU: 8.85
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74210 **Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 0.59
2021 NF PE RVU: 2.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74220 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** April 2016 **2019 est Medicare Utilization:** 196,573

2021 Work RVU: 0.60
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74221 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74230 **Radiologic examination, swallowing function, with cineradiography/videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Esophagus **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 370,056

2021 Work RVU: 0.53
2021 NF PE RVU: 3.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74240 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 53,309

2021 Work RVU: 0.80
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74241 **Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 25,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74245 **Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,946

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74246 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,438

2021 Work RVU: 0.90
2021 NF PE RVU: 3.26
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74247 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 21,591

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74248 **Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)**

Global: ZZZ **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74249 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 13,972

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

74250 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 52,021

2021 Work RVU: 0.81
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74251 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 1.17
2021 NF PE RVU: 10.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74260 **Duodenography, hypotonic**

Global: **Issue:** X-Ray Exam – Small Intestine/Colon **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 24

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

74270 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 28,934

2021 Work RVU: 1.04
2021 NF PE RVU: 3.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74280 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,205

2021 Work RVU: 1.26
2021 NF PE RVU: 5.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.26 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74300 **Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 29,648

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74301 **Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ACS, SAGES, SIR **First Identified:** October 2018 **2019 est Medicare Utilization:** 63

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74305 **Deleted from CPT**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74320 **Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74327 **Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74328 **Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 64,506

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74329 **Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 2,990

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74330 **Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 13,859

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74400 **Urography (pyelography), intravenous, with or without KUB, with or without tomography**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,180

2021 Work RVU: 0.49
2021 NF PE RVU: 3.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74420 **Urography, retrograde, with or without KUB**

Global: XXX **Issue:** X-Ray Urinary Tract **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 26 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 166,220

2021 Work RVU: 0.52
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74425 **Urography, antegrade, radiological supervision and interpretation**

Global: XXX **Issue:** Urography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, AUA, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,703

2021 Work RVU: 0.51
2021 NF PE RVU: 3.53
2021 Fac PE RVU: NA

RUC Recommendation: 0.51, editorially revised **Referred to CPT** September 2019 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74475 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74480 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74485 **Dilation of ureter(s) or urethra, radiological supervision and interpretation**

Global: XXX **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,628

2021 Work RVU: 0.83
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75561 **Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,956

2021 Work RVU: 2.60
2021 NF PE RVU: 9.39
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75572 **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,288

2021 Work RVU: 1.75
2021 NF PE RVU: 6.13
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** CMS Request - Final Rule for 2013 / High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, SIR, ACC **First Identified:** May 2013 **2019 est Medicare Utilization:** 86,531

2021 Work RVU: 2.40
2021 NF PE RVU: 9.10
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75625 **Aortography, abdominal, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 96,916

2021 Work RVU: 1.44
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75630 **Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 27,465

2021 Work RVU: 2.00
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography of Abdominal Arteries **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 114,472

2021 Work RVU: 2.40
2021 NF PE RVU: 10.42
2021 Fac PE RVU: NA

RUC Recommendation: 2.40 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

75650 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75671 **Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75680 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75710 **Angiography, extremity, unilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,614

2021 Work RVU: 1.75
2021 NF PE RVU: 2.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant and review after 2 years of data after publication available. 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2021

Status Report: CMS Requests and Relativity Assessment Issues

75716 **Angiography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 74,926

2021 Work RVU: 1.97
2021 NF PE RVU: 2.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75722 **Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75724 **Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75726 **Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 41,396

2021 Work RVU: 2.05
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75774 **Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 77,363

2021 Work RVU: 1.01
2021 NF PE RVU: 1.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75790 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75791 **Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75820 **Venography, extremity, unilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,689

2021 Work RVU: 1.05
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75822 **Venography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 10,692

2021 Work RVU: 1.48
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 348

2021 Work RVU: 1.44
2021 NF PE RVU: 2.64
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 525

2021 Work RVU: 1.44
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75894 **Transcatheter therapy, embolization, any method, radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,539

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** RAW will assess Oct 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75896 **Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation**

Global: **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 09 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 February 2015 May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75898 **Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis**

Global: XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,637

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant **Referred to CPT** February 2014 February 2015 **Result:** Contractor Price

Referred to CPT Asst ☑ **Published in CPT Asst:** September 2019

75940 **Percutaneous placement of IVC filter, radiological supervision and interpretation**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75945 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75946 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75952 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75953 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75954 **Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75960 **Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**

Global: **Issue:** RAW **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75961 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75962 **Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75964 **Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75966 **Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation**

Global:

Issue: Open and Percutaneous Transluminal Angioplasty

Screen: Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: January 2015

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

75968 **Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global:

Issue: Open and Percutaneous Transluminal Angioplasty

Screen: Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: January 2015

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

75978 **Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation**

Global:

Issue: Open and Percutaneous Transluminal Angioplasty

Screen: CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: April 2013

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

75980 **Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75982 **Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75984 **Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation**

Global: XXX **Issue:** Introduction of Catheter or Stent **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,664

2021 Work RVU: 0.83
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** RAW will assess Oct 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75992 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75993 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75994 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75995 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75996 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76000 **Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time** **Global:** XXX **Issue:** Fluoroscopy **Screen:** Low Value-Billed in Multiple Units / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 118,492

2021 Work RVU: 0.30
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76001 **Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)** **Global:** **Issue:** Fluoroscopy **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76098 **Radiological examination, surgical specimen** **Global:** XXX **Issue:** X-Ray Exam Specimen **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 68,182

2021 Work RVU: 0.31
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 5,269

2021 Work RVU: 0.58
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2

2021 Work RVU: 0.58
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2,408

2021 Work RVU: 0.58
2021 NF PE RVU: 4.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76376 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 23 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2017 **2019 est Medicare Utilization:** 276,317

2021 Work RVU: 0.20
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76377 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering with Interpretation and Report **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 30 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** July 2019 **2019 est Medicare Utilization:** 190,343

2021 Work RVU: 0.79
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: Survey **Referred to CPT** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76510 **Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 14,435

2021 Work RVU: 0.70
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76511 **Ophthalmic ultrasound, diagnostic; quantitative A-scan only** **Global:** XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,208

2021 Work RVU: 0.64
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76512 **Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)** **Global:** XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 220,526

2021 Work RVU: 0.56
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral** **Global:** XXX **Issue:** Ophthalmic Ultrasound Anterior Segment **Screen:** High Volume Growth1 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 17 **Specialty Developing Recommendation:** AAO, AOA (optometric), ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 26,263

2021 Work RVU: 0.60
2021 NF PE RVU: 1.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 and CPT Assistant article published **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2013

Status Report: CMS Requests and Relativity Assessment Issues

76514 **Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)**

Global: XXX **Issue:** Echo Exam of Eye Thickness **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 12 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2017 **2019 est Medicare Utilization:** 488,963

2021 Work RVU: 0.14
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76516 **Ophthalmic biometry by ultrasound echography, A-scan;**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,403

2021 Work RVU: 0.40
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76519 **Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 187,253

2021 Work RVU: 0.54
2021 NF PE RVU: 1.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation**

Global: XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2019 est Medicare Utilization:** 945,181

2021 Work RVU: 0.56
2021 NF PE RVU: 2.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76604 **Ultrasound, chest (includes mediastinum), real time with image documentation** **Global:** XXX **Issue:** Ultrasound Exam - Chest **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 106,091

2021 Work RVU: 0.59
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76641 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 647,984

2021 Work RVU: 0.73
2021 NF PE RVU: 2.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76642 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 769,119

2021 Work RVU: 0.68
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.68 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76645 **Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation** **Global:** **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76700 **Ultrasound, abdominal, real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 908,859

2021 Work RVU: 0.81
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76705 **Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,100,059

2021 Work RVU: 0.59
2021 NF PE RVU: 2.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76706 **Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)** **Global:** XXX **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** May 2015 **2019 est Medicare Utilization:** 159,273

2021 Work RVU: 0.55
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

76770 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,345,427

2021 Work RVU: 0.74
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76775 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 522,183

2021 Work RVU: 0.58
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.58 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76819 **Fetal biophysical profile; without non-stress testing**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 12,225

2021 Work RVU: 0.77
2021 NF PE RVU: 1.71
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

76830 **Ultrasound, transvaginal**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 442,342

2021 Work RVU: 0.69
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76856 **Ultrasound, pelvic (nonobstetric), real time with image documentation;**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 429,962

2021 Work RVU: 0.69
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76857 **Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 205,984

2021 Work RVU: 0.50
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76870 **Ultrasound, scrotum and contents**

Global: XXX **Issue:** Ultrasound Exam - Scrotum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 28 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 147,467

2021 Work RVU: 0.64
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76872 **Ultrasound, transrectal;**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 212,765

2021 Work RVU: 0.69
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76880 **Deleted from CPT**

Global: **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76881 **Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 196,753

2021 Work RVU: 0.63
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: Revised PE. RAW review in Jan 2022 **Referred to CPT** June 2017 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Winter 2011; Apr 2016

76882 **Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 288,120

2021 Work RVU: 0.49
2021 NF PE RVU: 1.13
2021 Fac PE RVU: NA

RUC Recommendation: Revised PE. RAW review in Jan 2022 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Summer and Winter 2011; Apr 2016

76930 **Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 2,662

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76932 **Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,241

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76936 **Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)**

Global: XXX **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** July 2013 **2019 est Medicare Utilization:** 810

2021 Work RVU: 1.99
2021 NF PE RVU: 5.68
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76937 **Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 637,782

2021 Work RVU: 0.30
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years (Jan 2022) **Referred to CPT** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76940 **Ultrasound guidance for, and monitoring of, parenchymal tissue ablation** **Global:** YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,403

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76942 **Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **Global:** XXX **Issue:** Ultrasound Guidance for Needle Placement **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: April 2014 **Tab:** 35 **Specialty Developing Recommendation:** AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,178,266

2021 Work RVU: 0.67
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT. 0.67 **Referred to CPT** May 2021 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76948 **Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation** **Global:** XXX **Issue:** Echo Guidance for Ova Aspiration **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 25 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2013 **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.67
2021 NF PE RVU: 1.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76950 **Ultrasonic guidance for placement of radiation therapy fields**

Global: **Issue:** Ultrasound Guidance **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76965 **Ultrasonic guidance for interstitial radioelement application**

Global: XXX **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** NO INTERESET **First Identified:** July 2013 **2019 est Medicare Utilization:** 6,316

2021 Work RVU: 1.34
2021 NF PE RVU: 1.31
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76970 **Ultrasound study follow-up (specify)**

Global: **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth1 / CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2019 est Medicare Utilization:** 25,085

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76998 **Ultrasonic guidance, intraoperative**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS **First Identified:** January 2019 **2019 est Medicare Utilization:** 29,381

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77001 **Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 310,854

2021 Work RVU: 0.38
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77002 **Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2015 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 528,759

2021 Work RVU: 0.54
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77003 **Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** October 2010 **2019 est Medicare Utilization:** 77,998

2021 Work RVU: 0.60
2021 NF PE RVU: 2.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77011 **Computed tomography guidance for stereotactic localization**

Global: XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 15 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** **2019 est Medicare Utilization:** 4,582

2021 Work RVU: 1.21
2021 NF PE RVU: 5.59
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77012 **Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation**

Global: XXX **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2016 **2019 est Medicare Utilization:** 210,656

2021 Work RVU: 1.50
2021 NF PE RVU: 2.73
2021 Fac PE RVU: NA

RUC Recommendation: Bundled 32405 and 77012. 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,401,373

2021 Work RVU: 0.85
2021 NF PE RVU: 2.72
2021 Fac PE RVU: NA

RUC Recommendation: Referred to CPT, but CMS has not addressed. RAW review action plan (Oct 2021).

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

77031 **Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77032 **Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77046 **Magnetic resonance imaging, breast, without contrast material; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 367

2021 Work RVU: 1.45
2021 NF PE RVU: 5.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.45

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77047 **Magnetic resonance imaging, breast, without contrast material; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 4,029

2021 Work RVU: 1.60
2021 NF PE RVU: 5.48
2021 Fac PE RVU: NA

RUC Recommendation: 1.60

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77048 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 1,164

2021 Work RVU: 2.10
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.10

Referred to CPT June 2017 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77049 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 87,710

2021 Work RVU: 2.30
2021 NF PE RVU: 8.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.30

Referred to CPT June 2017 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

77051 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified:

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77052 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified: October 2010

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77055 **Mammography; unilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77056 **Mammography; bilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77057 **Screening mammography, bilateral (2-view study of each breast)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77058 **Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77059 **Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77065 **Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 765,901

2021 Work RVU: 0.81
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77066 **Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 612,243

2021 Work RVU: 1.00
2021 NF PE RVU: 3.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77067 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,106,768

2021 Work RVU: 0.76
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 0.76 **Referred to CPT** October 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77073 **Bone length studies (orthoroentgenogram, scanogram)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 57,827

2021 Work RVU: 0.26
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77074 **Radiologic examination, osseous survey; limited (eg, for metastases)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,891

2021 Work RVU: 0.44
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77075 **Radiologic examination, osseous survey; complete (axial and appendicular skeleton)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 44,120

2021 Work RVU: 0.55
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77076 **Radiologic examination, osseous survey, infant**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 50

2021 Work RVU: 0.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77077 **Joint survey, single view, 2 or more joints (specify)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 39,322

2021 Work RVU: 0.33
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77079 **Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, AAFP, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77080 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,624,321

2021 Work RVU: 0.20
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77081 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: XXX **Issue:** Dual-energy X-Ray Absorptiometry (DXA) **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 42,987

2021 Work RVU: 0.20
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77082 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment**

Global: **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77083 **Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites**

Global: **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77085 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 110,730

2021 Work RVU: 0.30
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77086 **Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 1,925

2021 Work RVU: 0.17
2021 NF PE RVU: 0.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** May 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77261 **Therapeutic radiology treatment planning; simple**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 9,135

2021 Work RVU: 1.30
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.67

RUC Recommendation: 1.30

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77262 **Therapeutic radiology treatment planning; intermediate**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.00

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77263 **Therapeutic radiology treatment planning; complex**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 297,484

2021 Work RVU: 3.14
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.14

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77280 **Therapeutic radiology simulation-aided field setting; simple**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 370,105

2021 Work RVU: 0.70
2021 NF PE RVU: 7.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77285 **Therapeutic radiology simulation-aided field setting; intermediate**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,612

2021 Work RVU: 1.05
2021 NF PE RVU: 12.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77290 **Therapeutic radiology simulation-aided field setting; complex**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 210,211

2021 Work RVU: 1.56
2021 NF PE RVU: 12.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77293 **Respiratory motion management simulation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:** 31,536

2021 Work RVU: 2.00
2021 NF PE RVU: 10.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 142,124

2021 Work RVU: 4.29
2021 NF PE RVU: 9.58
2021 Fac PE RVU: NA

RUC Recommendation: 4.29 **Referred to CPT** October 2012, October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** MPC List / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,349,820

2021 Work RVU: 0.62
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** February 2014, October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications**

Global: XXX **Issue:** IMRT - PE Only **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes1 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:** 143,270

2021 Work RVU: 7.99
2021 NF PE RVU: 46.91
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 7.99. CPT Assistant article published.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009

77305 **Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77306 **Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,027

2021 Work RVU: 1.40
2021 NF PE RVU: 2.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.40

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77307 **Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 40,701

2021 Work RVU: 2.90
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77310 **Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77315 **Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77316 **Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 4,610

2021 Work RVU: 1.40
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77317 **Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 3,179

2021 Work RVU: 1.83
2021 NF PE RVU: 6.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77318 **Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 / RUC Request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 5,949

2021 Work RVU: 2.90
2021 NF PE RVU: 9.61
2021 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77326 **Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77327 **Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77328 **Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77332 **Treatment devices, design and construction; simple (simple block, simple bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 75,801

2021 Work RVU: 0.45
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77333 **Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 12,128

2021 Work RVU: 0.75
2021 NF PE RVU: 3.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77334 **Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)**

Global: XXX **Issue:** **Screen:** MPC List / RUC request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 845,243

2021 Work RVU: 1.15
2021 NF PE RVU: 2.47
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77336 **Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy**

Global: XXX **Issue:** Continuing Medical Physics Consultation-PE Only **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 31 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 412,038

2021 Work RVU: 0.00
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77338 **Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan**

Global: XXX **Issue:** IMRT - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 165,179

2021 Work RVU: 4.29
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77371 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based**

Global: XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** NA **2019 est Medicare Utilization:** 100

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77372 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:** 818

2021 Work RVU: 0.00
2021 NF PE RVU: 30.62
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77373 **Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASTRO, ACRO **First Identified:** July 2012 **2019 est Medicare Utilization:** 33,144

2021 Work RVU: 0.00
2021 NF PE RVU: 33.38
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77385 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77386 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77387 **Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77401 **Radiation treatment delivery, superficial and/or ortho voltage, per day**

Global: XXX **Issue:** Radiation Treatement Delivery (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 221,049

2021 Work RVU: 0.00
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** May 2019 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77402 **Radiation treatment delivery, >=1 MeV; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 and Feburary 2014 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77403 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77404 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77406 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77407 **Radiation treatment delivery, >=1 MeV; intermediate**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77408 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77409 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77411 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77412 **Radiation treatment delivery, >=1 MeV; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77413 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77414 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77416 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009 and Q&A - Mar 2010

77421 **Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77422 **High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking**

Global: **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77423 **High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)**

Global: XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77427 **Radiation treatment management, 5 treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,043,579

2021 Work RVU: 3.37
2021 NF PE RVU: 1.88
2021 Fac PE RVU: 1.88

RUC Recommendation: 3.45. Remove from high E/M screen. **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77435 **Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 38,142

2021 Work RVU: 11.87
2021 NF PE RVU: 5.81
2021 Fac PE RVU: 5.81

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77470 **Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)**

Global: XXX **Issue:** Special Radiation Treatment **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 41 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 91,885

2021 Work RVU: 2.03
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77520 **Proton treatment delivery; simple, without compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 256

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77522 **Proton treatment delivery; simple, with compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** January 2018 **2019 est Medicare Utilization:** 15,881

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77523 **Proton treatment delivery; intermediate**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** High Volume Growth4 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2016 **2019 est Medicare Utilization:** 47,302

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77525 **Proton treatment delivery; complex**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 20,144

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77600 **Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)**

Global: XXX **Issue:** Hyperthermia - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,464

2021 Work RVU: 1.31
2021 NF PE RVU: 12.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77767 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 5,362

2021 Work RVU: 1.05
2021 NF PE RVU: 6.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77768 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 7,665

2021 Work RVU: 1.40
2021 NF PE RVU: 9.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77770 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,117

2021 Work RVU: 1.95
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.95 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77771 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,697

2021 Work RVU: 3.80
2021 NF PE RVU: 13.63
2021 Fac PE RVU: NA

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77772 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,164

2021 Work RVU: 5.40
2021 NF PE RVU: 20.66
2021 Fac PE RVU: NA

RUC Recommendation: 5.40 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77776 **Interstitial radiation source application; simple**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77777 **Interstitial radiation source application; intermediate**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77778 **Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed**

Global: 000 **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,806

2021 Work RVU: 8.78
2021 NF PE RVU: 16.56
2021 Fac PE RVU: NA

RUC Recommendation: 8.78 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77781 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77782 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77790 **Supervision, handling, loading of radiation source**

Global: XXX **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 145

2021 Work RVU: 0.00
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78000 **Thyroid uptake; single determination** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78001 **Thyroid uptake; multiple determinations** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78003 **Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78006 **Thyroid imaging, with uptake; single determination** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78007 **Thyroid imaging, with uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78010 **Thyroid imaging; only**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78011 **Thyroid imaging; with vascular flow**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,653

2021 Work RVU: 0.19
2021 NF PE RVU: 2.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78013 **Thyroid imaging (including vascular flow, when performed);**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 0.37
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78014 **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 18,954

2021 Work RVU: 0.50
2021 NF PE RVU: 6.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78070 **Parathyroid planar imaging (including subtraction, when performed);**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 13,220

2021 Work RVU: 0.80
2021 NF PE RVU: 7.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

Status Report: CMS Requests and Relativity Assessment Issues

78071 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,974

2021 Work RVU: 1.20
2021 NF PE RVU: 9.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78072 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 12,267

2021 Work RVU: 1.60
2021 NF PE RVU: 11.34
2021 Fac PE RVU: NA

RUC Recommendation: 1.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78223 **Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function**

Global: **Issue:** Hepatobiliary Ductal System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78226 **Hepatobiliary system imaging, including gallbladder when present;**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 61,197

2021 Work RVU: 0.74
2021 NF PE RVU: 8.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78227 **Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 64,389

2021 Work RVU: 0.90
2021 NF PE RVU: 11.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78265 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,303

2021 Work RVU: 0.98
2021 NF PE RVU: 10.46
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

78266 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 313

2021 Work RVU: 1.08
2021 NF PE RVU: 11.62
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

Status Report: CMS Requests and Relativity Assessment Issues

78278 **Acute gastrointestinal blood loss imaging**

Global: XXX **Issue:** Acute GI Blood Loss Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 34 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 26,257

2021 Work RVU: 0.99
2021 NF PE RVU: 9.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.99 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78300 **Bone and/or joint imaging; limited area**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 6,808

2021 Work RVU: 0.62
2021 NF PE RVU: 6.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78305 **Bone and/or joint imaging; multiple areas**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,645

2021 Work RVU: 0.83
2021 NF PE RVU: 7.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78306 **Bone and/or joint imaging; whole body**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 262,283

2021 Work RVU: 0.86
2021 NF PE RVU: 7.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78429 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78430 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.67 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78431 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78432 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.07 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78433 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78434 **Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.63 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78451 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 35,912

2021 Work RVU: 1.38
2021 NF PE RVU: 8.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78452 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,787,846

2021 Work RVU: 1.62
2021 NF PE RVU: 12.21
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 1.00
2021 NF PE RVU: 7.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 10,009

2021 Work RVU: 1.34
2021 NF PE RVU: 11.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78459 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 3,214

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78460 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78461 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78464 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78465 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78472 **Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

Global: XXX **Issue:** Cardiac Blood Pool Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 35 **Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 18,051

2021 Work RVU: 0.98
2021 NF PE RVU: 5.64
2021 Fac PE RVU: NA

RUC Recommendation: 0.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78478 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78480 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78491 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 1,809

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78492 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** October 2016 **2019 est Medicare Utilization:** 179,360

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78579 **Pulmonary ventilation imaging (eg, aerosol or gas)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 360

2021 Work RVU: 0.49
2021 NF PE RVU: 4.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78580 **Pulmonary perfusion imaging (eg, particulate)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** SNM, ACR

First Identified: February 2010 **2019 est Medicare Utilization:** 10,224

2021 Work RVU: 0.74
2021 NF PE RVU: 6.14
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78582 **Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM

First Identified: February 2010 **2019 est Medicare Utilization:** 165,031

2021 Work RVU: 1.07
2021 NF PE RVU: 8.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78584 **Pulmonary perfusion imaging, particulate, with ventilation; single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78585 **Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78586 **Pulmonary ventilation imaging, aerosol; single projection**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78587 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78591 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78593 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78594 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78597 **Quantitative differential pulmonary perfusion, including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 0.75
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78598 **Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,383

2021 Work RVU: 0.85
2021 NF PE RVU: 8.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78803 **Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging**

Global: XXX **Issue:** RAW **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** January 2016 **2019 est Medicare Utilization:** 11,736

2021 Work RVU: 1.09
2021 NF PE RVU: 10.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78815 **Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2010 **2019 est Medicare Utilization:** 604,627

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Reaffirmed RUC recommendation **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

79101 **Radiopharmaceutical therapy, by intravenous administration**

Global: XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 12,142

2021 Work RVU: 1.96
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: Article published Feb 2012 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2012

80500 **Clinical pathology consultation; limited, without review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2019 **2019 est Medicare Utilization:** 21,998

2021 Work RVU: 0.37
2021 NF PE RVU: 0.25
2021 Fac PE RVU: 0.16

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

80502 **Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:** 13,114

2021 Work RVU: 1.33
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.60

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX0

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.50 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80XX1

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.91 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX2

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX3

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

85060 **Blood smear, peripheral, interpretation by physician with written report**

Global: XXX **Issue:** Blood Smear Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 30 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 185,409

2021 Work RVU: 0.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

85097 **Bone marrow, smear interpretation** **Global:** XXX **Issue:** Bone Marrow Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 31 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 140,727

2021 Work RVU: 0.94
2021 NF PE RVU: 1.01
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

85390 **Fibrinolysins or coagulopathy screen, interpretation and report** **Global:** XXX **Issue:** Fibrinolysins Screen **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 34,588

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

88104 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation** **Global:** XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 65,152

2021 Work RVU: 0.56
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88106 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,360

2021 Work RVU: 0.37
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88107 **Deleted from CPT**

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

Most Recent RUC Meeting: October 2010 **Tab:** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88108 **Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 229,625

2021 Work RVU: 0.44
2021 NF PE RVU: 1.37
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88112 **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 886,295

2021 Work RVU: 0.56
2021 NF PE RVU: 1.36
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88120 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 49,876

2021 Work RVU: 1.20
2021 NF PE RVU: 16.90
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88121 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 28,769

2021 Work RVU: 1.00
2021 NF PE RVU: 12.06
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88141 **Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 55,857

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88160 **Cytopathology, smears, any other source; screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,020

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88161 **Cytopathology, smears, any other source; preparation, screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,156

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88162 **Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 1,306

2021 Work RVU: 0.76
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88184 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker**

Global: XXX **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 104,681

2021 Work RVU: 0.00
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88185 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)**

Global: ZZZ **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 1,918,080

2021 Work RVU: 0.00
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88187 **Flow cytometry, interpretation; 2 to 8 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 42,225

2021 Work RVU: 0.74
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.74

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88188 **Flow cytometry, interpretation; 9 to 15 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 38,197

2021 Work RVU: 1.20
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.55

RUC Recommendation: 1.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88189 **Flow cytometry, interpretation; 16 or more markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 222,162

2021 Work RVU: 1.70
2021 NF PE RVU: 0.65
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88300 **Level I - Surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 207,562

2021 Work RVU: 0.08
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.08 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88302 **Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 75,443

2021 Work RVU: 0.13
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88304 **Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 967,907

2021 Work RVU: 0.22
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88305 **Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,561,979

2021 Work RVU: 0.75
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88307 **Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 983,152

2021 Work RVU: 1.59
2021 NF PE RVU: 6.65
2021 Fac PE RVU: NA

RUC Recommendation: 1.59 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88309 **Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 150,124

2021 Work RVU: 2.80
2021 NF PE RVU: 9.77
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88312 **Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,383,233

2021 Work RVU: 0.54
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 **Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,362,216

2021 Work RVU: 0.24
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 **Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,474

2021 Work RVU: 0.45
2021 NF PE RVU: 2.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318 **Deleted from CPT**

Global: **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 22 **Specialty Developing Recommendation:** CAP, AAD **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88319 **Special stain including interpretation and report; Group III, for enzyme constituents**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** **2019 est Medicare Utilization:** 17,807

2021 Work RVU: 0.53
2021 NF PE RVU: 3.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** June 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88321 **Consultation and report on referred slides prepared elsewhere**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 182,148

2021 Work RVU: 1.63
2021 NF PE RVU: 1.12
2021 Fac PE RVU: 0.71

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88323 **Consultation and report on referred material requiring preparation of slides**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 35,000

2021 Work RVU: 1.83
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88325 **Consultation, comprehensive, with review of records and specimens, with report on referred material**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 11,656

2021 Work RVU: 2.85
2021 NF PE RVU: 1.79
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

88329 **Pathology consultation during surgery;**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 27,870

2021 Work RVU: 0.67
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88331 **Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 448,638

2021 Work RVU: 1.19
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88332 **Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 163,257

2021 Work RVU: 0.59
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88333 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 69,359

2021 Work RVU: 1.20
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88334 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,996

2021 Work RVU: 0.73
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88341 **Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 3,097,983

2021 Work RVU: 0.56
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88342 **Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,040,539

2021 Work RVU: 0.70
2021 NF PE RVU: 2.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** May 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88343 **Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)**

Global: **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88344 **Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 132,224

2021 Work RVU: 0.77
2021 NF PE RVU: 4.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88346 **Immunofluorescence, per specimen; initial single antibody stain procedure** **Global:** XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,000

2021 Work RVU: 0.74
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88347 **Immunofluorescent study, each antibody; indirect method** **Global:** **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88348 **Electron microscopy, diagnostic** **Global:** XXX **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:** 17,170

2021 Work RVU: 1.51
2021 NF PE RVU: 10.80
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88349 **Electron microscopy; scanning**

Global: **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Oct 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88350 **Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2014 **2019 est Medicare Utilization:** 260,841

2021 Work RVU: 0.59
2021 NF PE RVU: 2.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88356 **Morphometric analysis; nerve**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 37 **Specialty Developing Recommendation:** ASCP, CAP **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,440

2021 Work RVU: 2.80
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88360 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 506,136

2021 Work RVU: 0.85
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88361 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 169,281

2021 Work RVU: 0.95
2021 NF PE RVU: 2.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88364 **In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 28,908

2021 Work RVU: 0.70
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88365 **In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 48,038

2021 Work RVU: 0.88
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88366 **In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 2,322

2021 Work RVU: 1.24
2021 NF PE RVU: 7.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88367 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,914

2021 Work RVU: 0.73
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

Status Report: CMS Requests and Relativity Assessment Issues

88368 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,780

2021 Work RVU: 0.88
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88373 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 6,229

2021 Work RVU: 0.58
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88374 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** **2019 est Medicare Utilization:** 113,039

2021 Work RVU: 0.93
2021 NF PE RVU: 9.15
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88377 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 152,595

2021 Work RVU: 1.40
2021 NF PE RVU: 10.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

90460 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:** 301

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90461 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:** 58

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90465 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90467 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2019 est Medicare Utilization:** 282,357

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request – Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2019 est Medicare Utilization:** 22,524

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

90473 **Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90785 **Interactive complexity (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 408,566

2021 Work RVU: 0.33
2021 NF PE RVU: 0.09
2021 Fac PE RVU: 0.04

RUC Recommendation: Refer to CPT Review in 3 years (Oct 2023). 0.33 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90791 **Psychiatric diagnostic evaluation**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 917,143

2021 Work RVU: 3.84
2021 NF PE RVU: 1.20
2021 Fac PE RVU: 0.50

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90792 **Psychiatric diagnostic evaluation with medical services**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 586,327

2021 Work RVU: 4.16
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.25 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90801 **Psychiatric diagnostic interview examination**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90805 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90806 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90808 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90818 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90832 **Psychotherapy, 30 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,306,870

2021 Work RVU: 1.70
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.22

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90833 **Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,401,042

2021 Work RVU: 1.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90834 **Psychotherapy, 45 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 4,939,452

2021 Work RVU: 2.24
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90836 **Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 510,888

2021 Work RVU: 1.90
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.34

RUC Recommendation: 1.90 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90837 **Psychotherapy, 60 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,027,217

2021 Work RVU: 3.31
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90838 **Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 100,884

2021 Work RVU: 2.50
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90839 **Psychotherapy for crisis; first 60 minutes**

Global: XXX **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 23,040

2021 Work RVU: 3.13
2021 NF PE RVU: 0.90
2021 Fac PE RVU: 0.41

RUC Recommendation: 3.13 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90840 **Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)** **Global:** ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,284

2021 Work RVU: 1.50
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90845 **Psychoanalysis** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2011 **Tab:** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,591

2021 Work RVU: 2.10
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.31

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90846 **Family psychotherapy (without the patient present), 50 minutes** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 21,975

2021 Work RVU: 2.40
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.40 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90847 **Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 178,166

2021 Work RVU: 2.50
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90853 **Group psychotherapy (other than of a multiple-family group)**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 906,163

2021 Work RVU: 0.59
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.59 **Referred to CPT** February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90862 **Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90863 **Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global: XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 40 **Specialty Developing Recommendation:** APA (HCPAC) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 0.48
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90868 **Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session**

Global: 000 **Issue:** **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:**

First Identified: January 2018 **2019 est Medicare Utilization:** 238,754

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 2 years (Oct 2020)

Referred to CPT **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

90870 **Electroconvulsive therapy (includes necessary monitoring)**

Global: 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 41 **Specialty Developing Recommendation:** APA

First Identified: October 2009 **2019 est Medicare Utilization:** 126,401

2021 Work RVU: 2.50
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.50

Referred to CPT **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

908X0

Global: **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

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

First Identified: February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Survey

Referred to CPT February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

90911 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry**

Global: **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AUA

First Identified: April 2017 **2019 est Medicare Utilization:** 28,865

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90912 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient**

Global: 000 **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.90
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.90 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90913 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.50 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90935 **Hemodialysis procedure with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,098,691

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 51,752

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 165,382

2021 Work RVU: 1.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 11,769

2021 Work RVU: 2.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90951 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 17

2021 Work RVU: 23.92
2021 NF PE RVU: 8.88
2021 Fac PE RVU: 8.88

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90952 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 4

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90953 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90954 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 571

2021 Work RVU: 15.98
2021 NF PE RVU: 5.66
2021 Fac PE RVU: 5.66

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90955 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 57

2021 Work RVU: 10.32
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90956 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 124

2021 Work RVU: 6.64
2021 NF PE RVU: 3.10
2021 Fac PE RVU: 3.10

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90957 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,539

2021 Work RVU: 15.46
2021 NF PE RVU: 6.19
2021 Fac PE RVU: 6.19

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90958 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 393

2021 Work RVU: 9.87
2021 NF PE RVU: 4.23
2021 Fac PE RVU: 4.23

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90959 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 292

2021 Work RVU: 6.19
2021 NF PE RVU: 2.93
2021 Fac PE RVU: 2.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90960 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,218,361

2021 Work RVU: 6.77
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 3.20

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90961 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 719,245

2021 Work RVU: 5.52
2021 NF PE RVU: 2.75
2021 Fac PE RVU: 2.75

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90962 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 213,048

2021 Work RVU: 3.57
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 2.11

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90963 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 229

2021 Work RVU: 12.09
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90964 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 934

2021 Work RVU: 10.25
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90965 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 9.80
2021 NF PE RVU: 4.26
2021 Fac PE RVU: 4.26

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90966 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,733

2021 Work RVU: 5.52
2021 NF PE RVU: 2.74
2021 Fac PE RVU: 2.74

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91038 **Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)**

Global: 000 **Issue:** Gastroenterological Tests **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 23 **Specialty Developing Recommendation:** AGA, ASGE **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,829

2021 Work RVU: 1.10
2021 NF PE RVU: 12.08
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91110 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 53,131

2021 Work RVU: 2.49
2021 NF PE RVU: 22.79
2021 Fac PE RVU: NA

RUC Recommendation: 2.49 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

91111 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 146

2021 Work RVU: 1.00
2021 NF PE RVU: 26.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

91132 **Electrogastrography, diagnostic, transcutaneous;**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 114

2021 Work RVU: 0.52
2021 NF PE RVU: 11.72
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91133 **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.66
2021 NF PE RVU: 12.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92065 **Orthoptic and/or pleoptic training, with continuing medical direction and evaluation**

Global: XXX **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 32,858

2021 Work RVU: 0.37
2021 NF PE RVU: 1.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.71 **Referred to CPT** February 2021 May 2020-Tab 37 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92081 **Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,708

2021 Work RVU: 0.30
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92082 **Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 122,984

2021 Work RVU: 0.40
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92083 **Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)**

Global: XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 46 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,969,637

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

920XX

Global: **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

92100 **Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)**

Global: XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 31,551

2021 Work RVU: 0.61
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,814,680

2021 Work RVU: 0.40
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2008 **2019 est Medicare Utilization:** 7,509,080

2021 Work RVU: 0.45
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92135 **Deleted from CPT**

Global: **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 31 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation**

Global: XXX **Issue:** Ophthalmic Biometry **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,688,098

2021 Work RVU: 0.54
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92140 **Provocative tests for glaucoma, with interpretation and report, without tonography**

Global: **Issue:** Glaucoma Provacative Tests **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 41 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92201 **Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.40
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.40 **Referred to CPT** February 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92202 **Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.26
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.15

RUC Recommendation: 0.26 **Referred to CPT** February 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92225 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** April 2017 **2019 est Medicare Utilization:** 947,451

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92226 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:** 2,551,942

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92235 **Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2011 **2019 est Medicare Utilization:** 428,183

2021 Work RVU: 0.75
2021 NF PE RVU: 2.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2015 **2019 est Medicare Utilization:** 10,668

2021 Work RVU: 0.80
2021 NF PE RVU: 5.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92242 **Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2015 **2019 est Medicare Utilization:** 37,989

2021 Work RVU: 0.95
2021 NF PE RVU: 6.37
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92250 **Fundus photography with interpretation and report**

Global: XXX **Issue:** Fundus Photography **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 45 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** October 2010 **2019 est Medicare Utilization:** 3,490,129

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92270 **Electro-oculography with interpretation and report**

Global: XXX **Issue:** Electro-oculography **Screen:** High Volume Growth1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,435

2021 Work RVU: 0.81
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published. **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2008 and Q&A Jun 2009

92273 **Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 68,699

2021 Work RVU: 0.69
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92274 **Electroretinography (ERG), with interpretation and report; multifocal (mfERG)** **Global:** XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.61
2021 NF PE RVU: 1.97
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.72 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92275 **Electroretinography with interpretation and report** **Global:** **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 17 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92284 **Dark adaptation examination with interpretation and report** **Global:** XXX **Issue:** Dark Adaption Eye Exam **Screen:** Harvard Valued - Utilization over 30,000-Part5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 20 **Specialty Developing Recommendation:** AAO, AOA (optometry), ASRS **First Identified:** October 2020 **2019 est Medicare Utilization:** 32,615

2021 Work RVU: 0.24
2021 NF PE RVU: 1.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.14. Review Technology **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)**

Global: XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 32 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:** 406,118

2021 Work RVU: 0.05
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.05 and new PE inputs **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92286 **Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 115,474

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92287 **Anterior segment imaging with interpretation and report; with fluorescein angiography**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** **2019 est Medicare Utilization:** 7,182

2021 Work RVU: 0.81
2021 NF PE RVU: 4.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2013

Status Report: CMS Requests and Relativity Assessment Issues

92504 **Binocular microscopy (separate diagnostic procedure)**

Global: XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 43 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 239,518

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing**

Global: **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth 3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2015 **2019 est Medicare Utilization:** 350,653

2021 Work RVU: 1.30
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 0.33
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92521 **Evaluation of speech fluency (eg, stuttering, cluttering)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 197

2021 Work RVU: 2.24
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92522 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 3,374

2021 Work RVU: 1.92
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92523 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 19,962

2021 Work RVU: 3.84
2021 NF PE RVU: 2.75
2021 Fac PE RVU: NA

RUC Recommendation: 3.36 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92524 **Behavioral and qualitative analysis of voice and resonance**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 18,441

2021 Work RVU: 1.92
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 133,424

2021 Work RVU: 1.34
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92537 **Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 68,931

2021 Work RVU: 0.60
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92538 **Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 6,794

2021 Work RVU: 0.30
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 89,363

2021 Work RVU: 1.50
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 13,573

2021 Work RVU: 0.40
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 19,332

2021 Work RVU: 0.48
2021 NF PE RVU: 0.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92543 **Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording**

Global: **Issue:** Vestibular Caloric Irrigation **Screen:** Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,943

2021 Work RVU: 0.27
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92545 **Oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,622

2021 Work RVU: 0.25
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92546 **Sinusoidal vertical axis rotational testing**

Global: XXX **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 43,026

2021 Work RVU: 0.29
2021 NF PE RVU: 3.16
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92547 **Use of vertical electrodes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:**

First Identified: February 2014 **2019 est Medicare Utilization:** 26,526

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92548 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:** AAA, AAN, ASHA

First Identified: February 2014 **2019 est Medicare Utilization:** 51,157

2021 Work RVU: 0.67
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.76

Referred to CPT September 2018 / February 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92549 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.87
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.96

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92550 **Tympanometry and reflex threshold measurements**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 231,898

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,255,685

2021 Work RVU: 0.60
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92558 **Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.17
2021 NF PE RVU: 0.10
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.17 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92567 **Tympanometry (impedance testing)** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 922,916

2021 Work RVU: 0.20
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.10

RUC Recommendation: 0.20 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92568 **Acoustic reflex testing, threshold** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,046

2021 Work RVU: 0.29
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.29 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92569 **Deleted from CPT** **Global:** **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 38,849

2021 Work RVU: 0.55
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92584 **Electrocochleography**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 11,016

2021 Work RVU: 1.00
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92585 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive**

Global: **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,565

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92586 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**

Global: **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 1,425

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92587 **Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2008 **2019 est Medicare Utilization:** 58,068

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92588 **Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 85,077

2021 Work RVU: 0.55
2021 NF PE RVU: 0.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 2,839

2021 Work RVU: 1.26
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92605 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.75
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.75 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.40
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.40 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 544

2021 Work RVU: 1.85
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 220

2021 Work RVU: 0.70
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92609 **Therapeutic services for the use of speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 14,910

2021 Work RVU: 1.50
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 **Evaluation of oral and pharyngeal swallowing function**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 22,897

2021 Work RVU: 1.30
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.68

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 9,673

2021 Work RVU: 1.34
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92618 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 0.65
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.25

RUC Recommendation: 0.65 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 **Evaluation of central auditory function, with report; initial 60 minutes**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 818

2021 Work RVU: 1.50
2021 NF PE RVU: 1.15
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92621 **Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 43

2021 Work RVU: 0.35
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 9,371

2021 Work RVU: 1.15
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92626 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** AAA, ASHA **First Identified:** NA **2019 est Medicare Utilization:** 29,623

2021 Work RVU: 1.40
2021 NF PE RVU: 1.17
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.40 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

92627 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 7,594

2021 Work RVU: 0.33
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 11

2021 Work RVU: 1.76
2021 NF PE RVU: 1.50
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92650 **Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.25
2021 NF PE RVU: 0.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92651 **Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.00
2021 NF PE RVU: 1.57
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92652 **Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92653 **Auditory evoked potentials; neurodiagnostic, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ACNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.05
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92920 **Percutaneous transluminal coronary angioplasty; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 24,084

2021 Work RVU: 9.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92921 **Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92924 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,282

2021 Work RVU: 11.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.09

RUC Recommendation: 11.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92925 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92928 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 254,826

2021 Work RVU: 10.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92929 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.44 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92933 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,416

2021 Work RVU: 12.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.27

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92934 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.50 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92937 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 18,930

2021 Work RVU: 10.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.80

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92938 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92941 **Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 41,108

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92943 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 9,129

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92944 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92960 **Cardioversion, elective, electrical conversion of arrhythmia; external**

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

Most Recent RUC Meeting: October 2010 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 201,622

2021 Work RVU: 2.00
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92973 **Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,130

2021 Work RVU: 3.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.14

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92980 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel** **Global:** **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92981 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)** **Global:** **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92982 **Percutaneous transluminal coronary balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92984 **Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92986 **Percutaneous balloon valvuloplasty; aortic valve**

Global: 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,857

2021 Work RVU: 22.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.90

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92992 **Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 76

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92993 **Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 1

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92995 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92996 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC

First Identified: October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93000 **Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC

First Identified: September 2011 **2019 est Medicare Utilization:** 11,883,535

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.17

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93005 **Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:** 460,887

2021 Work RVU: 0.00
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.00

Referred to CPT **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93010 **Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC

First Identified: October 2010

2019 est Medicare Utilization: 18,866,949

2021 Work RVU: 0.17
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.17

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93012 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93014 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93015 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 999,644

2021 Work RVU: 0.75
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. CPT Assistant published. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93016 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,047,732

2021 Work RVU: 0.45
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 96,453

2021 Work RVU: 0.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93018 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only**

Global: XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,241,516

2021 Work RVU: 0.30
2021 NF PE RVU: 0.11
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93025 **Microvolt T-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 213

2021 Work RVU: 0.75
2021 NF PE RVU: 3.15
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93040 **Rhythm ECG, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 108,714

2021 Work RVU: 0.15
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93041 **Rhythm ECG, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC

First Identified: February 2009 **2019 est Medicare Utilization:** 12,914

2021 Work RVU: 0.00
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE only)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93042 **Rhythm ECG, 1-3 leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC, ACEP

First Identified: October 2008 **2019 est Medicare Utilization:** 362,235

2021 Work RVU: 0.15
2021 NF PE RVU: 0.04
2021 Fac PE RVU: 0.04

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93224 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:** 284,557

2021 Work RVU: 0.39
2021 NF PE RVU: 1.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.52

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

93225 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 110,328

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 154,751

2021 Work RVU: 0.00
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93227 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 344,162

2021 Work RVU: 0.39
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.52 **Referred to CPT** Feburary 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93228 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 186,123

2021 Work RVU: 0.52
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93229 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 271,792

2021 Work RVU: 0.00
2021 NF PE RVU: 20.46
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93230 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93231 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93232 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93233 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93235 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 **Deleted from CPT**

Global: **Issue:** Cardiovascular Stress Test **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93237 **Deleted from CPT**

Global: **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93268 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 11,689

2021 Work RVU: 0.52
2021 NF PE RVU: 5.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93270 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 39,075

2021 Work RVU: 0.00
2021 NF PE RVU: 0.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93271 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,627

2021 Work RVU: 0.00
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93272 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 104,829

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93279 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 152,741

2021 Work RVU: 0.65
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93280 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 986,249

2021 Work RVU: 0.77
2021 NF PE RVU: 1.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93281 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 73,701

2021 Work RVU: 0.85
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93282 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 115,690

2021 Work RVU: 0.85
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93283 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,401

2021 Work RVU: 1.15
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.15 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93284 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 246,603

2021 Work RVU: 1.25
2021 NF PE RVU: 1.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93285 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 40,620

2021 Work RVU: 0.52
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93286 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 20,480

2021 Work RVU: 0.30
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93287 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,854

2021 Work RVU: 0.45
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93288 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 242,876

2021 Work RVU: 0.43
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93289 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 97,500

2021 Work RVU: 0.75
2021 NF PE RVU: 1.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93290 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 118,819

2021 Work RVU: 0.43
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93291 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,111

2021 Work RVU: 0.37
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93292 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,142

2021 Work RVU: 0.43
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93293 **Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 50,828

2021 Work RVU: 0.31
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,162,316

2021 Work RVU: 0.60
2021 NF PE RVU: 0.24
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 618,312

2021 Work RVU: 0.74
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93296 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,298,857

2021 Work RVU: 0.00
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs and Refer to CPT **Referred to CPT** February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93297 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 436,176

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93298 **Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 718,193

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93299 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 790,455

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93306 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography**

Global: XXX **Issue:** Complete Transthoracic Echocardiography (TTE) with Doppler **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 21 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 7,396,555

2021 Work RVU: 1.46
2021 NF PE RVU: 4.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93307 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 26,672

2021 Work RVU: 0.92
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93308 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 435,885

2021 Work RVU: 0.53
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,942

2021 Work RVU: 0.38
2021 NF PE RVU: 1.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93321 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC **First Identified:** October 2013 **2019 est Medicare Utilization:** 239,405

2021 Work RVU: 0.15
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93325 **Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC

First Identified: February 2009

2019 est Medicare Utilization: 606,488

2021 Work RVU: 0.07
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.07

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93350 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** Other - Identified by RUC / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: April 2008

2019 est Medicare Utilization: 95,788

2021 Work RVU: 1.46
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.46; CPT Assistant article published

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93351 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: July 2015

2019 est Medicare Utilization: 241,940

2021 Work RVU: 1.75
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.75

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93451 **Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 44,232

2021 Work RVU: 2.47
2021 NF PE RVU: 23.82
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 exempt list. 3.02 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93452 **Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,594

2021 Work RVU: 4.50
2021 NF PE RVU: 22.80
2021 Fac PE RVU: NA

RUC Recommendation: 4.32 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93453 **Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 2,368

2021 Work RVU: 5.99
2021 NF PE RVU: 28.76
2021 Fac PE RVU: NA

RUC Recommendation: 5.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93454 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 127,375

2021 Work RVU: 4.54
2021 NF PE RVU: 22.77
2021 Fac PE RVU: NA

RUC Recommendation: 4.95 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93455 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 27,649

2021 Work RVU: 5.29
2021 NF PE RVU: 25.34
2021 Fac PE RVU: NA

RUC Recommendation: 6.15 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93456 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 19,829

2021 Work RVU: 5.90
2021 NF PE RVU: 28.29
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93457 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,711

2021 Work RVU: 6.64
2021 NF PE RVU: 30.82
2021 Fac PE RVU: NA

RUC Recommendation: 7.66 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93458 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 507,961

2021 Work RVU: 5.60
2021 NF PE RVU: 25.90
2021 Fac PE RVU: NA

RUC Recommendation: 6.51 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93459 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 90,436

2021 Work RVU: 6.35
2021 NF PE RVU: 27.63
2021 Fac PE RVU: NA

RUC Recommendation: 7.34 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93460 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 89,701

2021 Work RVU: 7.10
2021 NF PE RVU: 30.59
2021 Fac PE RVU: NA

RUC Recommendation: 7.88 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93461 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 14,051

2021 Work RVU: 7.85
2021 NF PE RVU: 33.97
2021 Fac PE RVU: NA

RUC Recommendation: 9.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93462 **Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 3.73
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.73 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93463 **Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,287

2021 Work RVU: 2.00
2021 NF PE RVU: 0.70
2021 Fac PE RVU: 0.70

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93464 **Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,054

2021 Work RVU: 1.80
2021 NF PE RVU: 5.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93501 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93503 **Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 71,386

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.38

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93508 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93510 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More/ CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93511 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93514 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93524 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93526 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93527 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93528 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93529 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93539 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93540 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93541 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93542 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93543 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93544 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93545 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93555 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93556 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93561 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 6

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93562 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.95

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93563 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC

First Identified: **2019 est Medicare Utilization:** 167

2021 Work RVU: 1.11
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.00

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6

2021 Work RVU: 1.13
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93565 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 80

2021 Work RVU: 0.86
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93566 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 388

2021 Work RVU: 0.86
2021 NF PE RVU: 3.14
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 28,640

2021 Work RVU: 0.97
2021 NF PE RVU: 2.33
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.97 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93568 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,334

2021 Work RVU: 0.88
2021 NF PE RVU: 2.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93571 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2016 **2019 est Medicare Utilization:** 69,945

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93572 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,600

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93613 **Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 80,773

2021 Work RVU: 5.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93620 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording**

Global: 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,849

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 11.57 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93621 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 29,892

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93623 **Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pacing Heart Stimulation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2018 **2019 est Medicare Utilization:** 38,626

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Referral to CPT for parenthetical. 2.04 **Referred to CPT** May 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93641 **Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator**

Global: 000 **Issue:** Insertion/Removal of Pacemaker or Pacing Carioverter-Defibillator **Screen:** Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,210

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 2B. **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93651 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93653 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,821

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.40

RUC Recommendation: 15.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93654 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 7,750

2021 Work RVU: 19.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.55

RUC Recommendation: 18.10 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93655 **Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 /High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,147

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 53,327

2021 Work RVU: 19.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.63

RUC Recommendation: 17.00 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93657 **Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 21,959

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.26

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 63,470

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.53 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93668 **Peripheral arterial disease (PAD) rehabilitation, per session**

Global: XXX **Issue:** Peripheral Artery Disease (PAD) Rehabilitation (PE Only) **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** July 2017 **2019 est Medicare Utilization:** 814

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93701 **Bioimpedance-derived physiologic cardiovascular analysis** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 14,268

2021 Work RVU: 0.00
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

93731 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93732 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93733 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93743 **Deleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93744 **Deleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93750 **Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report**

Global: XXX **Issue:** Ventricular Assist Device (VAD) Interrogation **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 24 **Specialty Developing Recommendation:** AATS, ACC, STS **First Identified:** October 2018 **2019 est Medicare Utilization:** 97,423

2021 Work RVU: 0.75
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93792 **Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: September 2016 **2019 est Medicare Utilization:** 1,742

2021 Work RVU: 0.00
2021 NF PE RVU: 1.90
2021 Fac PE RVU: NA

RUC Recommendation: Reviewe in 2 years. 0.00 PE Only

Referred to CPT September 2016 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93793 **Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: September 2016 **2019 est Medicare Utilization:** 1,555,390

2021 Work RVU: 0.18
2021 NF PE RVU: 0.14
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years. 0.18

Referred to CPT September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93875 **Deleted from CPT**

Global: **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** SS in process of developing draft of CPT Asst article (Aug 2011). Code was deleted

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Status Report: CMS Requests and Relativity Assessment Issues

93880 **Duplex scan of extracranial arteries; complete bilateral study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ACC, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,198,611

2021 Work RVU: 0.80
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Addressed in CPT Coding Changes

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93882 **Duplex scan of extracranial arteries; unilateral or limited study** **Global:** XXX **Issue:** Duplex Scans **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,564

2021 Work RVU: 0.50
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93886 **Transcranial Doppler study of the intracranial arteries; complete study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 104,495

2021 Work RVU: 0.91
2021 NF PE RVU: 7.16
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93888 **Transcranial Doppler study of the intracranial arteries; limited study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,532

2021 Work RVU: 0.50
2021 NF PE RVU: 4.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93890 **Transcranial Doppler study of the intracranial arteries; vasoreactivity study** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 52,137

2021 Work RVU: 1.00
2021 NF PE RVU: 7.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

93892 **Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 55,222

2021 Work RVU: 1.15
2021 NF PE RVU: 8.14
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93895 **Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral**

Global: XXX **Issue:** Carotid Intima-Media Thickness Ultrasound **Screen:** New Code in CPT 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 37 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Rescind April 2014 recommendation, contractor price.

Referred to CPT **Result:** Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

93922 **Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 694,382

2021 Work RVU: 0.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.25

Referred to CPT February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93923 **Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 440,595

2021 Work RVU: 0.45
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,266

2021 Work RVU: 0.50
2021 NF PE RVU: 4.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925 **Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 661,535

2021 Work RVU: 0.80
2021 NF PE RVU: 6.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93926 **Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 262,918

2021 Work RVU: 0.50
2021 NF PE RVU: 3.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93930 **Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** November 2013 **2019 est Medicare Utilization:** 23,417

2021 Work RVU: 0.80
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93931 **Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 47,500

2021 Work RVU: 0.50
2021 NF PE RVU: 3.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93965 **Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)**

Global: **Issue:** Non-invasive Physiologic Studies of Extremity Veins **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 47 **Specialty Developing Recommendation:** ACC, ACR, SCAI, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93970 **Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,626,806

2021 Work RVU: 0.70
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93971 **Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Low Value-High Volume / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,753,619

2021 Work RVU: 0.45
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93975 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** November 2013 **2019 est Medicare Utilization:** 218,302

2021 Work RVU: 1.16
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 173,269

2021 Work RVU: 0.80
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93978 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 287,616

2021 Work RVU: 0.80
2021 NF PE RVU: 4.61
2021 Fac PE RVU: NA

RUC Recommendation: 0.97

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93979 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:**

First Identified: October 2013

2019 est Medicare Utilization: 66,512

2021 Work RVU: 0.50
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93982 **Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS

First Identified: January 2017

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93985 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.80
2021 NF PE RVU: 6.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93986 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)**

Global: XXX **Issue:** Doppler Flow Testing **Screen:** CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:** 132,133

2021 Work RVU: 0.50
2021 NF PE RVU: 3.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94010 **Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation**

Global: XXX **Issue:** Spirometry **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,234,541

2021 Work RVU: 0.17
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 47

2021 Work RVU: 0.52
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 38

2021 Work RVU: 0.00
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94016 **Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,244

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94060 **Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration**

Global: XXX **Issue:** Spirometry **Screen:** MPC List / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,160,195

2021 Work RVU: 0.22
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94200 **Maximum breathing capacity, maximal voluntary ventilation**

Global: XXX **Issue:** Lung Function Test **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 28 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 74,436

2021 Work RVU: 0.05
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.05

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94240 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94250 **Expired gas collection, quantitative, single procedure (separate procedure)**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 20,825

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94260 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 / **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94350 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94360 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94370 **Determination of airway closing volume, single breath tests**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94400 **Breathing response to CO2 (CO2 response curve)**

Global: **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** **2019 est Medicare Utilization:** 1,310

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94450 **Breathing response to hypoxia (hypoxia response curve)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 0.40
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94617 **Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 9,892

2021 Work RVU: 0.70
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94618 **Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 271,019

2021 Work RVU: 0.48
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94620 **Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)**

Global: **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94621 **Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** January 2016 **2019 est Medicare Utilization:** 21,378

2021 Work RVU: 1.42
2021 NF PE RVU: 3.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.42 **Referred to CPT** February 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94640 **Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 /CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 601,038

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94667 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 6,331

2021 Work RVU: 0.00
2021 NF PE RVU: 0.61
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94668 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 5,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs CPT Assistant article published **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

Status Report: CMS Requests and Relativity Assessment Issues

94669 **Mechanical chest wall oscillation to facilitate lung function, per session** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 324

2021 Work RVU: 0.00
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94681 **Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 7,816

2021 Work RVU: 0.20
2021 NF PE RVU: 1.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

94720 **Carbon monoxide diffusing capacity (eg, single breath, steady state)** **Global:** **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94725 **Membrane diffusion capacity**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94726 **Plethysmography for determination of lung volumes and, when performed, airway resistance**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 681,512

2021 Work RVU: 0.26
2021 NF PE RVU: 1.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 **Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 348,523

2021 Work RVU: 0.26
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94728 **Airway resistance by oscillometry** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,985

2021 Work RVU: 0.26
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94729 **Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,113,315

2021 Work RVU: 0.19
2021 NF PE RVU: 1.52
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94750 **Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)** **Global:** **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 18,981

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 29,834

2021 Work RVU: 0.00
2021 NF PE RVU: 0.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 16,501

2021 Work RVU: 0.00
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2019 est Medicare Utilization:** 208,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94770 **Carbon dioxide, expired gas determination by infrared analyzer**

Global: **Issue:** Evaluation of Wheezing **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,724

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

95004 **Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAAAI, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 10,738,966

2021 Work RVU: 0.01
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95010 **Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95012 **Nitric oxide expired gas determination** **Global:** XXX **Issue:** Exhaled Nitric Oxide Measurement (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAAAI, ACAAI, ATS, CHEST **First Identified:** October 2018 **2019 est Medicare Utilization:** 136,728

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 **Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests** **Global:** **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95017 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests** **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 27,662

2021 Work RVU: 0.07
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.07 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95018 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 129,391

2021 Work RVU: 0.14
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.14 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95024 **Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,833,929

2021 Work RVU: 0.01
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.01

RUC Recommendation: New PE Inputs. **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95027 **Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 164,524

2021 Work RVU: 0.01
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95115 **Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,034,318

2021 Work RVU: 0.00
2021 NF PE RVU: 0.26
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95117 **Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,769,382

2021 Work RVU: 0.00
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95144 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 178,622

2021 Work RVU: 0.06
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95148 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms**

Global: XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 20,261

2021 Work RVU: 0.06
2021 NF PE RVU: 2.59
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95165 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,687,749

2021 Work RVU: 0.06
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95249 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 08 **Specialty Developing Recommendation:** AACE, ES, ACP **First Identified:** **2019 est Medicare Utilization:** 10,730

2021 Work RVU: 0.00
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: PE Only. Referral to CPT Assistant **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** June 2018

Status Report: CMS Requests and Relativity Assessment Issues

95250 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES **First Identified:** October 2013 **2019 est Medicare Utilization:** 76,885

2021 Work RVU: 0.00
2021 NF PE RVU: 4.47
2021 Fac PE RVU: NA

RUC Recommendation: Re-review at RAW. New PE inputs. **Referred to CPT** October 2015 & February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95251 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES **First Identified:** April 2013 **2019 est Medicare Utilization:** 248,288

2021 Work RVU: 0.70
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.28

RUC Recommendation: Re-review at RAW. 0.70. **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95700 **Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95705 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95706 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95707 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95708 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95709 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95710 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95711 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95712 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95713 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95714 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95715 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95716 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95717 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.00
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.79

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95718 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.25
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95719 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.00
2021 NF PE RVU: 1.37
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95720 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95721 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95722 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 2.22

RUC Recommendation: 4.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95723 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.75
2021 NF PE RVU: 2.45
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95724 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: 2.84

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95725 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: 2.82
2021 Fac PE RVU: 2.61

RUC Recommendation: 5.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95726 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.58
2021 NF PE RVU: 3.83
2021 Fac PE RVU: 3.59

RUC Recommendation: 7.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95800 **Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 24,715

2021 Work RVU: 0.85
2021 NF PE RVU: 3.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95801 **Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 422

2021 Work RVU: 0.85
2021 NF PE RVU: 1.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** NA **2019 est Medicare Utilization:** 232

2021 Work RVU: 0.90
2021 NF PE RVU: 3.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 and New PE inputs **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95805 **Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,017

2021 Work RVU: 1.20
2021 NF PE RVU: 10.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95806 **Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 80,376

2021 Work RVU: 0.93
2021 NF PE RVU: 1.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 **Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,278

2021 Work RVU: 1.28
2021 NF PE RVU: 10.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95808 **Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,197

2021 Work RVU: 1.74
2021 NF PE RVU: 17.45
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** February 2010 **2019 est Medicare Utilization:** 272,131

2021 Work RVU: 2.50
2021 NF PE RVU: 15.30
2021 Fac PE RVU: NA

RUC Recommendation: 2.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95811 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 333,381

2021 Work RVU: 2.60
2021 NF PE RVU: 15.99
2021 Fac PE RVU: NA

RUC Recommendation: 2.60 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95812 **Electroencephalogram (EEG) extended monitoring; 41-60 minutes**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: July 2015

2019 est Medicare Utilization: 24,822

2021 Work RVU: 1.08
2021 NF PE RVU: 8.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.08

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

95813 **Electroencephalogram (EEG) extended monitoring; 61-119 minutes**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: July 2015

2019 est Medicare Utilization: 31,299

2021 Work RVU: 1.63
2021 NF PE RVU: 10.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.63

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95816 **Electroencephalogram (EEG); including recording awake and drowsy**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:**

First Identified: January 2012

2019 est Medicare Utilization: 278,212

2021 Work RVU: 1.08
2021 NF PE RVU: 9.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.08

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

95819 **Electroencephalogram (EEG); including recording awake and asleep**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: September 2011

2019 est Medicare Utilization: 202,028

2021 Work RVU: 1.08
2021 NF PE RVU: 12.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.08

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95822 **Electroencephalogram (EEG); recording in coma or sleep only**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 26,955

2021 Work RVU: 1.08
2021 NF PE RVU: 10.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95827 **Electroencephalogram (EEG); all night recording**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:** 5,020

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95831 **Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 79,780

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95832 **Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 11,062

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95833 **Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 867

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95834 **Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 605

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95860 **Needle electromyography; 1 extremity with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,418

2021 Work RVU: 0.96
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.96 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95861 **Needle electromyography; 2 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,204

2021 Work RVU: 1.54
2021 NF PE RVU: 3.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.54 **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 157

2021 Work RVU: 1.87
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.87 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,620

2021 Work RVU: 1.99
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: 1.99 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 **Needle electromyography; cranial nerve supplied muscle(s), unilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 0.79
2021 NF PE RVU: 2.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95868 **Needle electromyography; cranial nerve supplied muscles, bilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 5,630

2021 Work RVU: 1.18
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95869 **Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 447

2021 Work RVU: 0.37
2021 NF PE RVU: 2.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95870 **Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 52,835

2021 Work RVU: 0.37
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95885 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 141,249

2021 Work RVU: 0.35
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95886 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 962,501

2021 Work RVU: 0.86
2021 NF PE RVU: 2.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,870

2021 Work RVU: 0.71
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95900 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011& February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95903 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 and February 2012 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95904 **Nerve conduction, amplitude and latency/velocity study, each nerve; sensory**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95907 **Nerve conduction studies; 1-2 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 6,263

2021 Work RVU: 1.00
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95908 **Nerve conduction studies; 3-4 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 58,348

2021 Work RVU: 1.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95909 **Nerve conduction studies; 5-6 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 134,007

2021 Work RVU: 1.50
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.77 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95910 **Nerve conduction studies; 7-8 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 157,766

2021 Work RVU: 2.00
2021 NF PE RVU: 3.41
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95911 **Nerve conduction studies; 9-10 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 175,960

2021 Work RVU: 2.50
2021 NF PE RVU: 4.00
2021 Fac PE RVU: NA

RUC Recommendation: 3.34 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95912 **Nerve conduction studies; 11-12 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 78,978

2021 Work RVU: 3.00
2021 NF PE RVU: 4.50
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95913 **Nerve conduction studies; 13 or more studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 81,707

2021 Work RVU: 3.56
2021 NF PE RVU: 5.15
2021 Fac PE RVU: NA

RUC Recommendation: 4.20 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95921 **Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 / Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,178

2021 Work RVU: 0.90
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,986

2021 Work RVU: 0.96
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.96 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2008; Sep 2020

95923 **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2019 **2019 est Medicare Utilization:** 114,086

2021 Work RVU: 0.90
2021 NF PE RVU: 2.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

Status Report: CMS Requests and Relativity Assessment Issues

95924 **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** **2019 est Medicare Utilization:** 21,055

2021 Work RVU: 1.73
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 1.73 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95925 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,861

2021 Work RVU: 0.54
2021 NF PE RVU: 4.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95926 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,658

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95928 **Central motor evoked potential study (transcranial motor stimulation); upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 325

2021 Work RVU: 1.50
2021 NF PE RVU: 5.39
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95929 **Central motor evoked potential study (transcranial motor stimulation); lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,333

2021 Work RVU: 1.50
2021 NF PE RVU: 5.60
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95930 **Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report**

Global: XXX **Issue:** Visual Evoked Potential Testing **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 11 **Specialty Developing Recommendation:** AAO, AOA (optometry), ACNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 53,881

2021 Work RVU: 0.35
2021 NF PE RVU: 1.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** May 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95934 **H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95936 **H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95938 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 90,204

2021 Work RVU: 0.86

2021 NF PE RVU: 9.64

2021 Fac PE RVU: NA

RUC Recommendation: 0.86 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95939 **Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 41,818

2021 Work RVU: 2.25
2021 NF PE RVU: 13.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.25 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95940 **Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,807

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95941 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95943 **Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** January 2018 **2019 est Medicare Utilization:** 22,723

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95951 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 188,070

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 24,927

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95954 **Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 623

2021 Work RVU: 2.45
2021 NF PE RVU: 8.95
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 5,307

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

95957 **Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)** **Global:** XXX **Issue:** Electroencephalogram (EEG) Exended Monitoring **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 50 **Specialty Developing Recommendation:** AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,055

2021 Work RVU: 1.98
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95970 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,689

2021 Work RVU: 0.35
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95971 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 21,590

2021 Work RVU: 0.78
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.78 **Referred to CPT** February 2015, June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 46,946

2021 Work RVU: 0.80
2021 NF PE RVU: 0.76
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.80 **Referred to CPT** May 2014 February , June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95973 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, ACOG, ASA, AUA, ISIS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95974 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95975 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

Status Report: CMS Requests and Relativity Assessment Issues

95976 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 8,660

2021 Work RVU: 0.73
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.95 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95977 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 7,130

2021 Work RVU: 0.97
2021 NF PE RVU: 0.50
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.19 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95978 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95979 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95980 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 570

2021 Work RVU: 0.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.35

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95981 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 843

2021 Work RVU: 0.30
2021 NF PE RVU: 0.73
2021 Fac PE RVU: 0.17

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95982 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,278

2021 Work RVU: 0.65
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.31

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95983 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 40,522

2021 Work RVU: 0.91
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.25 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95984 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 58,079

2021 Work RVU: 0.80
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.40

RUC Recommendation: 1.00 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95990 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,124

2021 Work RVU: 0.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:** 8,596

2021 Work RVU: 0.77
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.77 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95992 **Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day**

Global: XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 112,529

2021 Work RVU: 0.75
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from Modifier -51 Exempt list. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96101 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96102 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96103 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS Request/Speech Language Pathology Request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,273

2021 Work RVU: 1.75
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96110 **Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96111 **Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96112 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 1,417

2021 Work RVU: 2.56
2021 NF PE RVU: 1.07
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96113 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 132

2021 Work RVU: 1.16
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.10 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96116 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,733

2021 Work RVU: 1.86
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.86 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96118 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96119 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96120 **Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96121 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 47,794

2021 Work RVU: 1.71
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.71 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96125 **Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 4,262

2021 Work RVU: 1.70
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96127 **Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 492,372

2021 Work RVU: 0.00
2021 NF PE RVU: 0.13
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96130 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 99,759

2021 Work RVU: 2.56
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.44

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96131 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 80,133

2021 Work RVU: 1.96
2021 NF PE RVU: 0.57
2021 Fac PE RVU: 0.29

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96132 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 194,323

2021 Work RVU: 2.56
2021 NF PE RVU: 1.16
2021 Fac PE RVU: 0.38

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96133 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 339,426

2021 Work RVU: 1.96
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96136 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 173,801

2021 Work RVU: 0.55
2021 NF PE RVU: 0.75
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.55 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96137 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 379,620

2021 Work RVU: 0.46
2021 NF PE RVU: 0.72
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.46 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96138 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 157,925

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96139 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 353,021

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96146 **Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 27,702

2021 Work RVU: 0.00
2021 NF PE RVU: 0.05
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96150 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 54,601

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96151 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 10,113

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96152 **Health and behavior intervention, each 15 minutes, face-to-face; individual**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 103,595

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96153 **Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:** 42,795

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96154 **Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** APA (psychology), NASW

First Identified: April 2017 **2019 est Medicare Utilization:** 8,583

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96155 **Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96156 **Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.10
2021 NF PE RVU: 0.60
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96158 **Health behavior intervention, individual, face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.45
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.45 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96159 **Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96164 **Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.21
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.21 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96165 **Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.10
2021 NF PE RVU: 0.03
2021 Fac PE RVU: 0.01

RUC Recommendation: 0.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96167 **Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.55
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96168 **Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.55
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96170 **Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.71
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96171 **Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.54
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.54 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96360 **Intravenous infusion, hydration; initial, 31 minutes to 1 hour**

Global: XXX **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 248,266

2021 Work RVU: 0.17
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96361 **Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 433,535

2021 Work RVU: 0.09
2021 NF PE RVU: 0.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.09 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96365 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**

Global: XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,269,889

2021 Work RVU: 0.21
2021 NF PE RVU: 1.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96366 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 558,744

2021 Work RVU: 0.18
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96367 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,292,846

2021 Work RVU: 0.19
2021 NF PE RVU: 0.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96368 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 133,379

2021 Work RVU: 0.17
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, AAFP, ACRh **First Identified:** April 2013 **2019 est Medicare Utilization:** 9,458,412

2021 Work RVU: 0.17
2021 NF PE RVU: 0.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 272,442

2021 Work RVU: 0.18
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: ZZZ **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,416,745

2021 Work RVU: 0.10
2021 NF PE RVU: 0.38
2021 Fac PE RVU: NA

RUC Recommendation: 0.10 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** should be on N/R LOI just added to track **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** January 2016 **2019 est Medicare Utilization:** 60,948

2021 Work RVU: 0.17
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Not Part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

96401 **Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 758,701

2021 Work RVU: 0.21
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 403,494

2021 Work RVU: 0.19
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96405 **Chemotherapy administration; intralesional, up to and including 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 12,359

2021 Work RVU: 0.52
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96406 **Chemotherapy administration; intralesional, more than 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 566

2021 Work RVU: 0.80
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.45

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 79,884

2021 Work RVU: 0.24
2021 NF PE RVU: 2.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96411 **Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 165,078

2021 Work RVU: 0.20
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96413 **Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875,219

2021 Work RVU: 0.28
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.28 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96415 **Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 891,855

2021 Work RVU: 0.19
2021 NF PE RVU: 0.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96416 **Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2019 est Medicare Utilization:** 30,942

2021 Work RVU: 0.21
2021 NF PE RVU: 3.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96417 **Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 388,626

2021 Work RVU: 0.21
2021 NF PE RVU: 1.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 60

2021 Work RVU: 2.12
2021 NF PE RVU: 25.94
2021 Fac PE RVU: 1.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96567 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day**

Global: XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth1 / CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 66,951

2021 Work RVU: 0.00
2021 NF PE RVU: 4.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 PE Only **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96573 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 39,219

2021 Work RVU: 0.48
2021 NF PE RVU: 6.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 48,673

2021 Work RVU: 1.01
2021 NF PE RVU: 7.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96910 **Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B**

Global: XXX **Issue:** Photo-chemotherapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 44 **Specialty Developing Recommendation:** AAD **First Identified:** July 2015 **2019 est Medicare Utilization:** 386,553

2021 Work RVU: 0.00
2021 NF PE RVU: 3.48
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 118,570

2021 Work RVU: 1.15
2021 NF PE RVU: 3.56
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.15. Review in two years (Jan 2022) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 29,878

2021 Work RVU: 1.30
2021 NF PE RVU: 3.85
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30. Review in two years (Jan 2022) **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Status Report: CMS Requests and Relativity Assessment Issues

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 15,528

2021 Work RVU: 2.10
2021 NF PE RVU: 4.86
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10. Review in two years (Jan 2022) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96X70 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** AACAP, AND, APA (psychology) **First Identified:** April 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

96X71 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** April 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

97001 **Physical therapy evaluation** **Global:** **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97002 **Physical therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97003 **Occupational therapy evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97004 **Occupational therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97010 **Application of a modality to 1 or more areas; hot or cold packs**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.06
2021 NF PE RVU: 0.11
2021 Fac PE RVU: NA

RUC Recommendation: No specialty society interest **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97012 **Application of a modality to 1 or more areas; traction, mechanical**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 560,317

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97014 **Application of a modality to 1 or more areas; electrical stimulation (unattended)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97016 **Application of a modality to 1 or more areas; vasopneumatic devices**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 864,521

2021 Work RVU: 0.18
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97018 **Application of a modality to 1 or more areas; paraffin bath**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 174,530

2021 Work RVU: 0.06
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97022 **Application of a modality to 1 or more areas; whirlpool**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 193,036

2021 Work RVU: 0.17
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97032 **Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 849,666

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97033 **Application of a modality to 1 or more areas; iontophoresis, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 56,451

2021 Work RVU: 0.26
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97034 **Application of a modality to 1 or more areas; contrast baths, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,235

2021 Work RVU: 0.21
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97035 **Application of a modality to 1 or more areas; ultrasound, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,002,641

2021 Work RVU: 0.21
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97110 **Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 60,569,850

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97112 **Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,084,367

2021 Work RVU: 0.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97113 **Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,811,269

2021 Work RVU: 0.48
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97116 **Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,661,789

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97127 **Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.50 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97140 **Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 29,711,740

2021 Work RVU: 0.43
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97150 **Therapeutic procedure(s), group (2 or more individuals)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** **Specialty Developing Recommendation:** APTA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,433,348

2021 Work RVU: 0.29
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97161 **Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,552,998

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97162 **Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,386,353

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97163 **Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 318,604

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97164 **Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 585,829

2021 Work RVU: 0.96
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97165 **Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 146,443

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97166 **Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 101,883

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97167 **Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 22,637

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97168 **Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 33,480

2021 Work RVU: 0.96
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97530 **Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,151,706

2021 Work RVU: 0.44
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97532 **Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth2 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97533 **Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 21,250

2021 Work RVU: 0.48
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97535 **Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,942,480

2021 Work RVU: 0.45
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Article no longer necessary

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97537 **Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 23,275

2021 Work RVU: 0.48
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97542 **Wheelchair management (eg, assessment, fitting, training), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,278

2021 Work RVU: 0.48
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97597 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

Global: 000 **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 897,614

2021 Work RVU: 0.77
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97598 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 135,670

2021 Work RVU: 0.50
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97602 **Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 51,268

2021 Work RVU: 0.55
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,612

2021 Work RVU: 0.60
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97607 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 5,825

2021 Work RVU: 0.41
2021 NF PE RVU: 9.58
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97608 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,172

2021 Work RVU: 0.46
2021 NF PE RVU: 9.26
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97610 **Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 12,331

2021 Work RVU: 0.40
2021 NF PE RVU: 11.52
2021 Fac PE RVU: 0.12

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Tests and Measures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,693

2021 Work RVU: 0.62
2021 NF PE RVU: 0.47
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

97760 **Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 57,907

2021 Work RVU: 0.50
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,698

2021 Work RVU: 0.50
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97762 **Checkout for orthotic/prosthetic use, established patient, each 15 minutes**

Global: **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 38,754

2021 Work RVU: 0.48
2021 NF PE RVU: 1.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 224,711

2021 Work RVU: 0.53
2021 NF PE RVU: 0.53
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 211,418

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98925 **Osteopathic manipulative treatment (OMT); 1-2 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 65,014

2021 Work RVU: 0.46
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.20

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98926 **Osteopathic manipulative treatment (OMT); 3-4 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 109,622

2021 Work RVU: 0.71
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98927 **Osteopathic manipulative treatment (OMT); 5-6 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 99,716

2021 Work RVU: 0.96
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98928 **Osteopathic manipulative treatment (OMT); 7-8 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010

2019 est Medicare Utilization: 99,045

2021 Work RVU: 1.21
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.25

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98929 **Osteopathic manipulative treatment (OMT); 9-10 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010

2019 est Medicare Utilization: 76,576

2021 Work RVU: 1.46
2021 NF PE RVU: 0.94
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.50

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98940 **Chiropractic manipulative treatment (CMT); spinal, 1-2 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011

2019 est Medicare Utilization: 5,600,246

2021 Work RVU: 0.46
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.46

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98941 **Chiropractic manipulative treatment (CMT); spinal, 3-4 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011

2019 est Medicare Utilization: 13,626,398

2021 Work RVU: 0.71
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.26

RUC Recommendation: 0.71

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98942 **Chiropractic manipulative treatment (CMT); spinal, 5 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:** 948,986

2021 Work RVU: 0.96
2021 NF PE RVU: 0.54
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.96 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98943 **Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions**

Global: XXX **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.46
2021 NF PE RVU: 0.29
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99143 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99144 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99148 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99149 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99150 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99151 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 11

2021 Work RVU: 0.50
2021 NF PE RVU: 1.99
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99152 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,909,615

2021 Work RVU: 0.25
2021 NF PE RVU: 1.24
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99155 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 30

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99156 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 7,955

2021 Work RVU: 1.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99174 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.15
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99177 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** May 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99183 **Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session**

Global: XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACEP, ACP, ACS, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 386,280

2021 Work RVU: 2.11
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

99281 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 67,730

2021 Work RVU: 0.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99282 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 352,496

2021 Work RVU: 0.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99283 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 2,744,710

2021 Work RVU: 1.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.42 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99284 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,415,650

2021 Work RVU: 2.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.54

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99285 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 11,514,274

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99354 **Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: **Tab:** **Specialty Developing Recommendation:** **First Identified:** February 2021 **2019 est Medicare Utilization:** 275,153

2021 Work RVU: 2.33
2021 NF PE RVU: 1.22
2021 Fac PE RVU: 0.98

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99355 **Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: **Tab:** **Specialty Developing Recommendation:** **First Identified:** February 2021 **2019 est Medicare Utilization:** 28,804

2021 Work RVU: 1.77
2021 NF PE RVU: 0.88
2021 Fac PE RVU: 0.67

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99356 **Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting:
Tab:
Specialty Developing Recommendation:
First Identified: February 2021
2019 est Medicare Utilization: 237,672
2021 Work RVU: 1.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.80

RUC Recommendation: Deleted from CPT
Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

99357 **Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting:
Tab:
Specialty Developing Recommendation:
First Identified: February 2021
2019 est Medicare Utilization: 15,885
2021 Work RVU: 1.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.81

RUC Recommendation: Deleted from CPT
Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result: Deleted from CPT

99358 **Prolonged evaluation and management service before and/or after direct patient care; first hour**

Global: XXX **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020
Tab: 12
Specialty Developing Recommendation: AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE
First Identified: November 2019
2019 est Medicare Utilization: 211,314
2021 Work RVU: 2.10
2021 NF PE RVU: 0.95
2021 Fac PE RVU: 0.95

RUC Recommendation: Refer to CPT
Referred to CPT February 2021
Referred to CPT Asst ☐ **Published in CPT Asst:**
Result:

Status Report: CMS Requests and Relativity Assessment Issues

99359 **Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 12 **Specialty Developing Recommendation:** AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE **First Identified:** November 2019 **2019 est Medicare Utilization:** 7,861

2021 Work RVU: 1.00
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.47

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99363 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99364 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99375 **Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

99378 **Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

993X0

Global: **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: **Tab:** **Specialty Developing Recommendation:** **First Identified:** February 2021 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Survey **Referred to CPT** February 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

99415 **Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2019 est Medicare Utilization:** 4,248 **2021 Work RVU:** 0.00 **2021 NF PE RVU:** 0.28 **2021 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** September 2021, February 2021 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

99416 **Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for outpatient Evaluation and Management service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2019 est Medicare Utilization:** 1,382 **2021 Work RVU:** 0.00 **2021 NF PE RVU:** 0.15 **2021 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** September 2021, February 2021 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99417

Global: XXX **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting:

Tab:

Specialty Developing Recommendation:

First Identified: November 2021

2019 est Medicare Utilization:

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Survey

Referred to CPT February 2021

Result:

Referred to CPT Asst ☐ **Published in CPT Asst:**

99491 **Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.**

Global: XXX **Issue:** Chronic Care Management Services **Screen:** New and Revised Service (Not part of RAW) **Complete?** Yes

Most Recent RUC Meeting: April 2017

Tab: 09

Specialty Developing Recommendation: AAFP, AAN, ACP, AGS

First Identified: NA

2019 est Medicare Utilization: 48,091

2021 Work RVU: 1.45
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.45. Refer to CPT Assistant

Referred to CPT

Result: Not part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2018

Status Report: CMS Requests and Relativity Assessment Issues

99492 **Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,445

2021 Work RVU: 1.88
2021 NF PE RVU: 2.41
2021 Fac PE RVU: 0.68

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99493 **Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 14,660

2021 Work RVU: 2.05
2021 NF PE RVU: 2.24
2021 Fac PE RVU: 0.76

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 27,335

2021 Work RVU: 0.82
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.30

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99497 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate**

Global: XXX **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,825,276

2021 Work RVU: 1.50
2021 NF PE RVU: 0.86
2021 Fac PE RVU: 0.65

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

99498 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 60,204

2021 Work RVU: 1.40
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.63

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

G0008 **Administration of influenza virus vaccine**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0009 **Administration of pneumococcal vaccine** **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0010 **Administration of hepatitis b vaccine** **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0101 **Cervical or vaginal cancer screening; pelvic and clinical breast examination** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2010 **2019 est Medicare Utilization:** 929,962

2021 Work RVU: 0.45
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0102 **Prostate cancer screening; digital rectal examination** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 30,358

2021 Work RVU: 0.18
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0104 **Colorectal cancer screening; flexible sigmoidoscopy** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,724

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0105 **Colorectal cancer screening; colonoscopy on individual at high risk** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 262,478

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0108 **Diabetes outpatient self-management training services, individual, per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 172,612

2021 Work RVU: 0.90
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0109 **Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 111,248

2021 Work RVU: 0.25
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0121 **Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215,409

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0124 **Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 47,978

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0127 **Trimming of dystrophic nails, any number**

Global: 000 **Issue:** **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** APMA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,109,311

2021 Work RVU: 0.17
2021 NF PE RVU: 0.52
2021 Fac PE RVU: 0.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0141 **Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 3,666

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0166 **External counterpulsation, per treatment session**

Global: XXX **Issue:** External Counterpulsation **Screen:** CMS-Other - Utilization over 100,000 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACC **First Identified:** April 2016 **2019 est Medicare Utilization:** 95,502

2021 Work RVU: 0.00
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE Only) **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0168 **Wound closure utilizing tissue adhesive(s) only**

Global: 000 **Issue:** Wound Closure by Adhesive **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 34 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** July 2016 **2019 est Medicare Utilization:** 44,921

2021 Work RVU: 0.31
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0179 **Physician re-certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 806,300

2021 Work RVU: 0.45
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0180 **Physician certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,169,998

2021 Work RVU: 0.67
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0181 **Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 386,948

2021 Work RVU: 1.73
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0182 **Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 26,148

2021 Work RVU: 1.73
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0202 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0204 **Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0206 **Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,969

2021 Work RVU: 0.00
2021 NF PE RVU: 0.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0238 **Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 49,322

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0248 **Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** January 2016 **2019 est Medicare Utilization:** 23,312

2021 Work RVU: 0.00
2021 NF PE RVU: 1.87
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0249 **Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,211,835

2021 Work RVU: 0.00
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0250 **Physician review, interpretation, and patient management of home inr testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 185,069

2021 Work RVU: 0.18
2021 NF PE RVU: 0.04
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Impacted Cerumen **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 35 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 166,164

2021 Work RVU: 0.61
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2019 est Medicare Utilization:** 81,177

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: Maintain/Remove from screen **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0279 **Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)**

Global: ZZZ **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 783,467

2021 Work RVU: 0.60
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: Recommend CMS delete **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,523,149

2021 Work RVU: 0.18
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0296 **Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019

2019 est Medicare Utilization: 50,164

2021 Work RVU: 0.52
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.20

RUC Recommendation: Submit action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G0297 **Low dose ct scan (ldct) for lung cancer screening**

Global: **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:**

First Identified: October 2018

2019 est Medicare Utilization: 260,400

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Recommend CMS delete. Cat I code created.

Referred to CPT May 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

G0364 **Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

G0365 **Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)**

Global: **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 38,289

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0389 **Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening**

Global: **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACC, ACP, ACR, SCAI, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

G0396 **Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AAFP, ASA, ASAM **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,068

2021 Work RVU: 0.65
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT **Referred to CPT** Time Uncertain **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0399 **Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation**

Global: XXX **Issue:** **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 112,455

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: CMS delete **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0402 **Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment**

Global: XXX **Issue:** Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 526,509

2021 Work RVU: 2.60
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 1.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0403 **Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report**

Global: XXX **Issue:** EKG for Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 129,413

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0407 **Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2019 est Medicare Utilization:** 54,207

2021 Work RVU: 1.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.57

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:**

G0408 **Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2019 est Medicare Utilization:** 28,734

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.82

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:**

G0416 **Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method**

Global: XXX **Issue:** Prostate Biopsy - Pathology **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2014 **2019 est Medicare Utilization:** 133,021

2021 Work RVU: 3.60
2021 NF PE RVU: 6.46
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0422 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,034

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0423 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 45,564

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0436 **Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0438 **Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,114,054

2021 Work RVU: 2.60
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0439 **Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 8,360,475

2021 Work RVU: 1.92
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0442 **Annual alcohol misuse screening, 15 minutes**

Global: XXX **Issue:** Annual Alcohol Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 893,133

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0444 **Annual depression screening, 15 minutes**

Global: XXX **Issue:** Annual Depression Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,127,052

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0446 **Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes**

Global: XXX **Issue:** Intensive Behavioral Therapy for Cardiovascular Disease **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** October 2017 **2019 est Medicare Utilization:** 253,992

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: Survey, but no specialty interest, so no recommendation.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0447 **Face-to-face behavioral counseling for obesity, 15 minutes**

Global: XXX **Issue:** Behavioral Counseling for Obesity **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 336,973

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0452 **Molecular pathology procedure; physician interpretation and report**

Global: XXX **Issue:** Molecular Pathology Interpretation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 128,942

2021 Work RVU: 0.93
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.93

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0453 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:**

First Identified: April 2016

2019 est Medicare Utilization: 402,739

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.30

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0456 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0457 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0500 **Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 490,072

2021 Work RVU: 0.10
2021 NF PE RVU: 1.57
2021 Fac PE RVU: 0.04

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0506 **Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)**

Global: ZZZ **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 119,106

2021 Work RVU: 0.87
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.37

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G6001 **Ultrasonic guidance for placement of radiation therapy fields**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AADA, ASTRO **First Identified:** October 2020 **2019 est Medicare Utilization:** 124,968

2021 Work RVU: 0.58
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G6002 **Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization: 1,291,326

2021 Work RVU: 0.39
2021 NF PE RVU: 1.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G6012 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 357,383

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6013 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 218,027

2021 Work RVU: 0.00
2021 NF PE RVU: 7.59
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

G6014 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 22,014

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G6015 **Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:** 1,297,349

2021 Work RVU: 0.00
2021 NF PE RVU: 11.01
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6017 **Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment**

Global: YYY **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:** 86,769

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

GPCX1 **Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)**

Global: **Issue:** Visit Complexity E/M Add-On **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: No recommendation on physician work, time or PE for this code. CMS estimates of utilization for code GPC1X should be more conservative.

Referred to CPT **Result:** N/A

Referred to CPT Asst ☐ **Published in CPT Asst:**

P3001 **Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 1,599

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Q0091 **Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** No Specialty Society Interest

First Identified: October 2018 **2019 est Medicare Utilization:** 533,729

2021 Work RVU: 0.37
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

CPT	2021 Long Descriptor	Issue	Most Recent RUC Meeting Date	Tab	Next RUC Review	RUC or RAW to Review	Specialty Society to Survey	RUC Recommendation	Screen	First Identified - RUC Meeting Date	Global	2021 work RVU	2021Non-Fac PE RVU	2021 Fac PE RVU	2021 PLI RVU	2019e Medicare Utilization	Referred to CPT Asst	CPT Asst Status	CPT Asst Complete	Referred to CPT	Refer to CPT Background	CPT Meeting	CPT Tab	CPT Ed Panel Status Complete	Complete	Result
00534	Anesthesia for transve	RAW	January 2019	37			ASA	Remove from screen	High Volume Growth5	October 2018	XXX	7	0.00	0.00	0.00	30,245	FALSE			FALSE					TRUE	Remove from Screen
00537	Anesthesia for cardiac	Anesthesia for Cardiac I	October 2020	13			ASA	12	High Volume Growth4	October 2016	XXX	7	0.00	0.00	0.00	89,969	FALSE			FALSE					TRUE	Increase
00560	Anesthesia for proced	RAW	January 2019	37			ASA	Remove from screen	High Volume Growth5	October 2018	XXX	15	0.00	0.00	0.00	58,933	FALSE			FALSE					TRUE	Remove from Screen
00731	Anesthesia for upper	Anesthesia for Intestina	January 2017	04			ASA	5 base units	CMS Request - Final Rule for 20	September 2016	XXX	5	0.00	0.00	0.00	1,262,160	FALSE			FALSE	In September 2016 the CPT	September 2016	12	yes	TRUE	Maintain
00732	Anesthesia for upper	Anesthesia for Intestina	January 2017	04			ASA	6 base units	CMS Request - Final Rule for 20	September 2016	XXX	6	0.00	0.00	0.00	105,226	FALSE			FALSE	In September 2016 the CPT	September 2016	12	yes	TRUE	Increase
00740	Anesthesia for upper	Anesthesia for Intestina	January 2017	04			ASA	Deleted from CPT	CMS Request - Final Rule for 20	July 2015							FALSE			TRUE	In April 2016, an Ad Hoc Ar	September 2016	12	yes	TRUE	Deleted from CPT
00810	Anesthesia for lower i	Anesthesia for Intestina	January 2017	04			ASA	Deleted from CPT	CMS Request - Final Rule for 20	July 2015							FALSE			TRUE	In April 2016, an Ad Hoc Ar	September 2016	12	yes	TRUE	Deleted from CPT
00811	Anesthesia for lower i	Anesthesia for Intestina	April 2017	04			ASA	4 base units	CMS Request - Final Rule for 20	September 2016	XXX	4	0.00	0.00	0.00	1,186,122	FALSE			FALSE	In September 2016 the CPT	September 2016	12	yes	TRUE	Decrease
00812	Anesthesia for lower i	Anesthesia for Intestina	April 2017	04			ASA	3 base units	CMS Request - Final Rule for 20	September 2016	XXX	3	0.00	0.00	0.00	517,650	FALSE			FALSE	In September 2016 the CPT	September 2016	12	yes	TRUE	Decrease
00813	Anesthesia for combir	Anesthesia for Intestina	January 2017	04			ASA	5 base units	CMS Request - Final Rule for 20	September 2016	XXX	5	0.00	0.00	0.00	492,977	FALSE			FALSE	In September 2016 the CPT	September 2016	12	yes	TRUE	Maintain
00918	Anesthesia for transu	Anesthesia for transure	January 2021	29				Maintain	High Volume Growth7	October 2020	XXX	5	0.00	0.00	0.00	101,565	FALSE			FALSE					TRUE	Remove from screen
01916	Anesthesia for diagnostic arteriography/veno		October 2020	23	October 2023	RAW		Review action plan	High Volume Growth6	October 2019	XXX	5	0.00	0.00	0.00	58,939	FALSE			FALSE					FALSE	
0191T	Insertion of anterior s	Cataract Removal with	January 2021	16			AAO	Deleted from CPT	High Volume Category III Codes	October 2019	XXX	0	0.00	0.00	0.00	57,829	FALSE			TRUE	At the April 2019 RUC mee	October 2020	37	complete	TRUE	Deleted from CPT
01930	Anesthesia for therap	Anesthesia for Interven	February 2008	S			ASA	Remove from screen	High Volume Growth1	February 2008	XXX	5	0.00	0.00	0.00	17,980	FALSE			FALSE					TRUE	Remove from Screen
01935	Anesthesia for percut	Anesthesia for Services for	January 2021	04			ASA	Deleted from CPT	High Volume Growth4	January 2021	XXX	5	0.00	0.00	0.00	19,793	FALSE			FALSE		October 2020	15	complete	TRUE	Deleted from CPT
01936	Anesthesia for percut	Anesthesia for Services for	January 2021	04			ASA	Deleted from CPT	High Volume Growth4	October 2016	XXX	5	0.00	0.00	0.00	311,884	FALSE			TRUE	This service was identifed	October 2020	15	complete	TRUE	Deleted from CPT
01937		Anesthesia Services for	January 2021	04			ASA	4	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Decrease
01938		Anesthesia Services for	January 2021	04			ASA	4	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Decrease
01939		Anesthesia Services for	January 2021	04			ASA	4	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Decrease
01940		Anesthesia Services for	January 2021	04			ASA	4	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Decrease
01941		Anesthesia Services for	January 2021	04			ASA	6	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Increase
01942		Anesthesia Services for	January 2021	04			ASA	6	High Volume Growth4	January 2021							FALSE			FALSE		October 2020	15	complete	TRUE	Increase
0275T	Percutaneous laminotomy/laminectomy (inte		January 2020	37				Maintain	High Volume Category III Codes	October 2019	YYY	0.00	0.00	0.00	0.00	2,656	FALSE			FALSE					TRUE	Maintain
0376T	Insertion of anterior s	Cataract Removal with	January 2021	16			AAO	Deleted from CPT	High Volume Category III Codes	October 2019	XXX	0.00	0.00	0.00	0.00	16,708	FALSE			TRUE	At the April 2019 RUC mee	October 2020	37	complete	TRUE	Deleted from CPT
0379T	Visual field assessment, with concurrent real t		January 2020	37	October 2023	RAW		Review in 3 years (Oct 2023)	High Volume Category III Codes	October 2019	XXX	0.00	0.00	0.00	0.00	49,050	FALSE			FALSE					FALSE	
0394T	High dose rate electronic brachytherapy, skin		January 2020	37	October 2023	RAW		Review in 3 years (Oct 2023)	High Volume Category III Codes	October 2019	XXX	0.00	0.00	0.00	0.00	28,857	FALSE			FALSE					FALSE	
0446T	Creation of subcutane	Insertion/ Removal of I	January 2020	33			AACE, ES	Contractor Price	CMS Request - Final Rule for 20	November 2019	000	1.14	53.70	0.44	0.09		FALSE			TRUE	In the CY 2020 Final Rule, (	February 2021	46	Renewed !	TRUE	Contractor Price
0447T	Removal of implantab	Insertion/ Removal of I	January 2020	33			AACE, ES	Contractor Price	CMS Request - Final Rule for 20	November 2019	000	1.34	1.55	0.52	0.11		FALSE			TRUE	In the CY 2020 Final Rule, (	February 2021	46	Renewed !	TRUE	Contractor Price
0448T	Removal of implantab	Insertion/ Removal of I	January 2020	33			AACE, ES	Contractor Price	CMS Request - Final Rule for 20	November 2019	000	1.91	53.16	0.74	0.15		FALSE			TRUE	In the CY 2020 Final Rule, (	February 2021	46	Renewed !	TRUE	Contractor Price
0449T	Insertion of aqueous drainage device, without		January 2020	37				Maintain	High Volume Category III Codes	October 2019	YYY	0.00	0.00	0.00	0.00	5,679	FALSE			FALSE					TRUE	Maintain
0474T	Insertion of anterior segment aqueous draina		January 2020	37				Maintain	High Volume Category III Codes	October 2019	XXX	0.00	0.00	0.00	0.00	12	FALSE			FALSE					TRUE	Maintain
0509T	Electroretinography (E	Electroretinography	January 2021	29	January 2024	RAW		Review action plan	Work Neutrality 2019	October 2020	XXX	0.40	1.84	NA	0.02	41,106	FALSE			FALSE					FALSE	Remove from Screen
0608T		Cataract Removal with	January 2021	16			AAO	Contractor Price	High Volume Category III Codes	January 2021							FALSE			FALSE	At the April 2019 RUC mee	October 2020	37	complete	TRUE	Contractor Price
10004	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				0.80	CMS High Expenditure Procedur	June 2017	ZZZ	0.80	0.59	0.34	0.11	503	FALSE			FALSE					TRUE	Decrease
10005	Fine needle aspiration	Fine Needle Aspiration	January 2020	21				1.63	CMS High Expenditure Procedur	June 2017	XXX	1.46	2.38	0.50	0.15	145,323	FALSE			FALSE					TRUE	Decrease
10006	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				1.00	CMS High Expenditure Procedur	June 2017	ZZZ	1.00	0.67	0.37	0.10	33,658	FALSE			FALSE					TRUE	Decrease
10007	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				1.81	CMS High Expenditure Procedur	June 2017	XXX	1.81	7.06	0.67	0.19	395	FALSE			FALSE					TRUE	Decrease
10008	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				1.18	CMS High Expenditure Procedur	June 2017	ZZZ	1.18	3.52	0.41	0.11	32	FALSE			FALSE					TRUE	Decrease
10009	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				2.43	CMS High Expenditure Procedur	June 2017	XXX	2.26	11.44	0.78	0.21	5,300	FALSE			FALSE					TRUE	Decrease
10010	Fine needle aspiration	Fine Needle Aspiration	October 2017	04				1.65	CMS High Expenditure Procedur	June 2017	ZZZ	1.65	6.42	0.56	0.15	99	FALSE			FALSE					TRUE	Decrease
10011	Fine needle aspiration	Fine Needle Aspiration	January 2018	04				Contractor Price	CMS High Expenditure Procedur	June 2017	XXX	0.00	0.00	0.00	0.00	69	FALSE			FALSE					TRUE	Contractor Price
10012	Fine needle aspiration	Fine Needle Aspiration	January 2018	04				Contractor Price	CMS High Expenditure Procedur	June 2017	ZZZ	0.00	0.00	0.00	0.00	21	FALSE			FALSE					TRUE	Contractor Price
10021	Fine needle aspiration	Fine Needle Aspiration	January 2020	21			AACE, ASB	1.20	CMS Request - Final Rule for 20	July 2015	XXX	1.03	1.85	0.44	0.14	17,957	FALSE			TRUE	The specialty societies gav	June 2017	06	yes	TRUE	Decrease
10022	Fine needle aspiration	Fine Needle Aspiration	October 2017	04			AACE, ASB	Deleted from CPT	CMS Fastest Growing / CMS Hig	October 2008							FALSE			TRUE	The specialty societies gav	June 2017	06	yes	TRUE	Deleted from CPT
10030	Image-guided fluid co	Drainage of Abscess	January 2013	04			ACR, SIR	3.00	Codes Reported Together 75%	January 2012	000	2.75	16.52	0.94	0.26	8,525	FALSE			FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Decrease
10040	Acne surgery (eg, mar	Acne Surgery	April 2016	13			AAD	0.91	Harvard Valued - Utilization ove	October 2015	010	0.91	2.42	0.52	0.09	41,492	FALSE			FALSE					TRUE	Decrease
10060	Incision and drainage	Incision and Drainage o	October 2010	07			APMA	1.50	Harvard Valued - Utilization ove	February 2010	010	1.22	2.27	1.66	0.13	368,976	FALSE			FALSE					TRUE	Increase
10061	Incision and drainage	Incision and Drainage o	January 2020	37			APMA	Maintain. 2.45	Harvard Valued - Utilization ove	October 2009	010	2.45	3.45	2.57	0.31	134,001	FALSE			FALSE					TRUE	Maintain
10120	Incision and removal of foreign body, subcuta		September 2011	12			APMA, AA	1.25	Harvard Valued - Utilization ove	April 2011	010	1.22	3.14	1.68	0.14	43,240	FALSE			FALSE					TRUE	Maintain
10180	Incision and drainage, complex, postoperative		October 2013	18				Remove from re-review	RUC identified when reviewing	January 2013	010	2.30	4.99	2.44	0.48	9,692	FALSE			FALSE					TRUE	Maintain
11040	Deleted from CPT	Excision and Debrideme	September 2007	16			APMA, AP	Deleted from CPT	Site of Service Anomaly	September 2007							FALSE			TRUE	Descriptor enables a bi-mo	October 2009	15	Code Dele	TRUE	Deleted from CPT
11041	Deleted from CPT	Excision and Debrideme	September 2007	16			APMA, AP	Deleted from CPT	Site of Service Anomaly	September 2007							FALSE			TRUE	Descriptor enables a bi-mo	October 2009	15	Code Dele	TRUE	Deleted from CPT
11042	Debridement, subcuta	Excision and Debrideme	February 2010	04			APMA, AP	1.12	Site of Service Anomaly	September 2007	000	1.01	2.68	0.62	0.13	1,938,307	FALSE			TRUE	Descriptor enables a bi-mo	October 2009	15	Complete	TRUE	Increase
11043	Debridement, muscle	Debridement	February 2010	04			APMA, AP	3.00	Site of Service Anomaly	September 2007	000	2.70	3.78	1.40	0.42	456,527	FALSE			TRUE	Descriptor enables a bi-mo	October 2009	15	Complete	TRUE	Decrease
11044	Debridement, bone (in	Debridement	February 2010	04			APMA, AP	4.56	Site of Service Anomaly	September 2007	000	4.10	4.42	1.83	0.64	88,567	FALSE			TRUE	Descriptor enables a bi-mo	October 2009	15	Complete	TRUE	Increase
11045	Debridement, subcuta	Excision and Debrideme	February 2010	04			ACS, APM/	0.69	Site of Service Anomaly	February 2010	ZZZ	0.50	0.62	0.18	0.09	492,140	FALSE			FALSE					TRUE	Increase
11046	Debridement, muscle	Debridement	February 2010	04			ACS, APM/	1.29	Site of Service Anomaly	February 2010	ZZZ	1.03	0.94	0.40	0.20	239,254	FALSE			FALSE					TRUE	Decrease
11047	Debridement, bone (in	Debridement	January 2020	37			ACS, APM/	2.00	Site of Service Anomaly / High V	February 2010	ZZZ	1.80	1.44	0.71	0.34	66,673	FALSE			FALSE					TRUE	Increase
11055	Paring or cutting of be	RAW Review	January 2012	30			APMA	Maintain	CMS Request to Re-Review Fam	November 2011	000	0.35	1.66	0.08	0.04	886,591	FALSE			FALSE					TRUE	Maintain
11056	Paring or cutting of be	Trim Skin Lesions	January 2012	53			APMA	0.50	MPC List / CMS Request to Re-R	October 2010	000	0.50	1.81	0.11	0.04	2,010,288	FALSE			FALSE					TRUE	Decrease
11057	Paring or cutting of be	RAW Review	January 2012	30			APMA	Maintain	CMS Request to Re-Review Fam	November 2011	000	0.65	1.88	0.14	0.05	346,586	FALSE			FALSE					TRUE	Maintain
11100	Biopsy of skin, subcut	Biopsy of Skin Lesion	April 2017	05			AAD	Deleted from CPT	MPC List / CMS High Expenditur	October 2010							FALSE			TRUE	Prior to the January 2016 R	February 2017	65	yes	TRUE	Deleted from CPT
11101	Biopsy of skin, subcut	Biopsy of Skin Lesion	April 2017	05			AAD	Deleted from CPT	Low Value Billed in Multiple Uni	October 2010							FALSE			TRUE	Prior to the January 2016 R	February 2017	65	yes	TRUE	Deleted from CPT
11102	Tangential biopsy of s	Skin Biopsy	April 2017	05				0.66	CMS High Expenditure Procedur	February 2017	000	0.66	2.34	0.38	0.05	3,333,585	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11103	Tangential biopsy of s	Skin Biopsy	April 2017	05				0.38	CMS High Expenditure Procedur	February 2017	ZZZ	0.38	1.13	0.22	0.04	1,456,282	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11104	Punch biopsy of skin (	Skin Biopsy	April 2017	05				0.83	CMS High Expenditure Procedur	February 2017	000	0.83	2.90	0.46	0.09	388,339	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11105	Punch biopsy of skin (	Skin Biopsy	April 2017	05				0.45	CMS High Expenditure Procedur	February 2017	ZZZ	0.45	1.29	0.25	0.05	97,094	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11106	Incisional biopsy of sk	Skin Biopsy	April 2017	05				1.01	CMS High Expenditure Procedur	February 2017	000	1.01	3.55	0.56	0.11	37,327	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11107	Incisional biopsy of sk	Skin Biopsy	April 2017	05				0.54	CMS High Expenditure Procedur	February 2017	ZZZ	0.54	1.55	0.31	0.05	7,020	FALSE			FALSE		February 2017	65	yes	TRUE	Decrease
11300	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	0.60	CMS High Expenditure Procedur	January 2012	000	0.60	2.38	0.33	0.05	104,786	FALSE			FALSE					TRUE	Increase
11301	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	0.90	CMS High Expenditure Procedur	January 2012	000	0.90	2.67	0.50	0.09	205,570	FALSE			FALSE					TRUE	Increase
11302	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.16	CMS High Expenditure Procedur	January 2012	000	1.05	3.02	0.59	0.11	114,770	FALSE			FALSE					TRUE	Increase
11303	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.25	CMS High Expenditure Procedur	January 2012	000	1.25	3.22	0.69	0.13	16,712	FALSE			FALSE					TRUE	Increase
11305	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	0.80	CMS High Expenditure Procedur	January 2012	000	0.80	2.32	0.24	0.06	100,773	FALSE			FALSE					TRUE	Increase
11306	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.18	CMS High Expenditure Procedur	January 2012	000	0.96	2.63	0.39	0.09	102,882	FALSE			FALSE					TRUE	Increase
11307	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.20	CMS High Expenditure Procedur	January 2012	000	1.20	2.95	0.54	0.11	51,111	FALSE			FALSE					TRUE	Increase
11308	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.46	CMS High Expenditure Procedur	January 2012	000	1.46	2.93	0.51	0.13	14,010	FALSE			FALSE					TRUE	Increase
11310	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.19	CMS High Expenditure Procedur	January 2012	000	0.80	2.60	0.44	0.09	74,188	FALSE			FALSE					TRUE	Increase
11311	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.43	CMS High Expenditure Procedur	January 2012	000	1.10	2.89	0.61	0.13	100,460	FALSE			FALSE					TRUE	Increase
11312	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	1.80	CMS High Expenditure Procedur	January 2012	000	1.30	3.26	0.73	0.14	46,378	FALSE			FALSE					TRUE	Increase
11313	Shaving of epidermal	Shaving of Epidermal or	April 2012	38			AAD	2.00	CMS High Expenditure Procedur	January 2012	000	1.68	3.60	0.94	0.17	8,180	FALSE			FALSE					TRUE	Increase
11719	Trimming of nondystr	Debridement of Nail	January 2012	32			APMA	0.17	Low Value-High Volume	October 2010	000	0.17	0.23	0.04	0.01	837,707	FALSE			FALSE					TRUE	Maintain
11720	Debridement of nail(s	Debridement of Nail	September 2011	53			APMA	0.32 (Interim)	MPC List	Septemer 2011	000	0.32	0.61	0.07	0.04	2,111,275	FALSE			FALSE					TRUE	Maintain
11721	Debridement of nail(s	Debridement of Nail	September 2011	53			APMA	0.54 (Interim)	MPC List	October 2010	000	0.54	0.72	0.12	0.04	6,784,854	FALSE			FALSE					TRUE	Maintain
11730	Avulsion of nail plate,	Removal of Nail Plate	January 2016	56			APMA	1.10	CMS High Expenditure Procedur	July 2015	000	1.05	2.29	0.43	0.09	378,522	FALSE			FALSE					TRUE	Maintain
11750	Excision of nail and na	Excision of Nail Bed - H	September 2014	26	RUC Review work ar			1.99	010-Day Global Post-Operative	January 2014	010	1.58	3.06	1.25	0.13	201,719	FALSE			FALSE					TRUE	Decrease
11752	Excision of nail and na	Excision of Nail Bed - H	January 2015	28				Deleted from CPT	010-Day Global Post-Operative	January 2014							FALSE			TRUE	The American Podiatric Me	October 2015	09	Code Dele	TRUE	Deleted from CPT
11755	Biopsy of nail unit (eg	Biopsy of Nail	April 2017	41i			APMA	1.25	CMS 000-Day Global Typically R	July 2016	000	1.25	2.38	0.43	0.10	62,237	FALSE			FALSE					TRUE	Decrease
11900	Injection, intralesiona	Skin Injection Services	April 2010	31			AAD	0.52	Harvard Valued - Utilization ove	October 2009	000	0.52	1.08	0.30	0.05	265,694	FALSE			FALSE					TRUE	Maintain
11901	Injection, intralesiona	Skin Injection Services	April 2010	31			AAD	0.80	Harvard Valued - Utilization ove	February 2010	000	0.80	1.17	0.46	0.09	73,970	FALSE			FALSE					TRUE	Maintain
11980	Subcutaneous hormor	Drug Delivery Implant P	October 2018	05			AAOS, ACC	1.10	High Volume Growth2 / Differer	April 2013	000	1.10	1.54	0.39	0.14	33,888	FALSE			TRUE	In January 2018, this servic	May 2018	10	Yes	TRUE	Decrease
11981	Insertion, non-biodeg	Drug Delivery Implant P	October 2018	05			AAOS, ACC	1.30	High Volume Growth1 / Differer	June 2008	000	1.14	1.70	0.52	0.21	13,060	FALSE			TRUE	In January 2018, this servic	May 2018	10	Yes	TRUE	Decrease

11982	Removal, non-biodegr	Drug Delivery Implant P	October 2018	05	AAOS, ACC	1.70	High Volume Growth	1 / Differe	February 2008	000	1.34	1.85	0.61	0.25	4,500	FALSE		TRUE	In January 2018, this servic	May 2018	10	Yes	TRUE	Decrease
11983	Removal with reinsert	Drug Delivery Implant P	October 2018	05	AAOS, ACC	2.10	High Volume Growth	1	June 2008	000	1.91	2.03	0.81	0.32	2,345	FALSE		FALSE					TRUE	Decrease
12001	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	0.84	Harvard Valued - Utilization ove		October 2009	000	0.84	1.77	0.31	0.15	184,284	FALSE		FALSE					TRUE	Decrease
12002	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.14	Harvard Valued - Utilization ove		October 2009	000	1.14	1.99	0.37	0.21	142,967	FALSE		FALSE					TRUE	Decrease
12004	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.44	Harvard Valued - Utilization ove		April 2010	000	1.44	2.18	0.44	0.26	22,345	FALSE		FALSE					TRUE	Decrease
12005	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.97	Harvard Valued - Utilization ove		April 2010	000	1.97	2.84	0.46	0.38	6,059	FALSE		FALSE					TRUE	Decrease
12006	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	2.39	Harvard Valued - Utilization ove		April 2010	000	2.39	3.22	0.59	0.45	1,137	FALSE		FALSE					TRUE	Decrease
12007	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	2.90	Harvard Valued - Utilization ove		April 2010	000	2.90	3.42	0.81	0.58	357	FALSE		FALSE					TRUE	Decrease
12011	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.07	Harvard Valued - Utilization ove		April 2010	000	1.07	2.06	0.35	0.21	90,553	FALSE		FALSE					TRUE	Decrease
12013	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.22	Harvard Valued - Utilization ove		April 2010	000	1.22	2.02	0.26	0.23	50,435	FALSE		FALSE					TRUE	Decrease
12014	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.57	Harvard Valued - Utilization ove		April 2010	000	1.57	2.37	0.33	0.30	6,842	FALSE		FALSE					TRUE	Decrease
12015	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	1.98	Harvard Valued - Utilization ove		April 2010	000	1.98	2.74	0.42	0.38	3,321	FALSE		FALSE					TRUE	Decrease
12016	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	2.68	Harvard Valued - Utilization ove		April 2010	000	2.68	3.30	0.59	0.51	526	FALSE		FALSE					TRUE	Decrease
12017	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	3.18	Harvard Valued - Utilization ove		April 2010	000	3.18	NA	0.67	0.64	72	FALSE		FALSE					TRUE	Decrease
12018	Simple repair of super	Repair of Superficial Wo	April 2010	32	ACEP, AAF	3.61	Harvard Valued - Utilization ove		April 2010	000	3.61	NA	0.74	0.74	17	FALSE		FALSE					TRUE	Decrease
12031	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.00	Harvard Valued - Utilization ove		February 2010	010	2.00	5.54	2.15	0.25	63,049	FALSE		FALSE					TRUE	Decrease
12032	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.52	Harvard Valued - Utilization ove		October 2009	010	2.52	6.28	2.71	0.26	280,457	FALSE		FALSE					TRUE	Maintain
12034	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.97	Harvard Valued - Utilization ove		February 2010	010	2.97	6.53	2.60	0.41	25,707	FALSE		FALSE					TRUE	Maintain
12035	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	3.60	Harvard Valued - Utilization ove		February 2010	010	3.50	7.58	2.92	0.64	4,889	FALSE		FALSE					TRUE	Increase
12036	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	4.50	Harvard Valued - Utilization ove		February 2010	010	4.23	7.86	3.22	0.84	1,073	FALSE		FALSE					TRUE	Increase
12037	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	5.25	Harvard Valued - Utilization ove		February 2010	010	5.00	8.45	3.61	1.02	458	FALSE		FALSE					TRUE	Increase
12041	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.10	Harvard Valued - Utilization ove		February 2010	010	2.10	5.46	1.86	0.26	20,831	FALSE		FALSE					TRUE	Decrease
12042	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.79	Harvard Valued - Utilization ove		February 2010	010	2.79	6.05	2.58	0.31	52,449	FALSE		FALSE					TRUE	Maintain
12044	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	3.19	Harvard Valued - Utilization ove		February 2010	010	3.19	7.68	2.57	0.45	2,304	FALSE		FALSE					TRUE	Maintain
12045	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	3.90	Harvard Valued - Utilization ove		February 2010	010	3.75	7.69	3.48	0.64	337	FALSE		FALSE					TRUE	Increase
12046	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	4.60	Harvard Valued - Utilization ove		February 2010	010	4.30	9.67	3.99	1.04	89	FALSE		FALSE					TRUE	Increase
12047	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	5.50	Harvard Valued - Utilization ove		February 2010	010	4.95	10.26	4.23	1.21	50	FALSE		FALSE					TRUE	Increase
12051	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	2.33	Harvard Valued - Utilization ove		February 2010	010	2.33	5.76	2.29	0.28	54,376	FALSE		FALSE					TRUE	Decrease
12052	Repair, intermediate,	Repair of Intermediate	April 2010	45	AAO-HNS,	Remove from screen	Harvard Valued - Utilization ove		February 2010	010	2.87	6.10	2.58	0.34	75,683	FALSE		FALSE					TRUE	Remove from Screen
12053	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	3.17	Harvard Valued - Utilization ove		February 2010	010	3.17	7.28	2.66	0.43	9,218	FALSE		FALSE					TRUE	Maintain
12054	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	3.50	Harvard Valued - Utilization ove		February 2010	010	3.50	7.45	2.32	0.54	2,576	FALSE		FALSE					TRUE	Maintain
12055	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	4.65	Harvard Valued - Utilization ove		February 2010	010	4.50	9.72	3.43	0.79	281	FALSE		FALSE					TRUE	Increase
12056	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	5.50	Harvard Valued - Utilization ove		February 2010	010	5.30	11.05	5.03	0.94	41	FALSE		FALSE					TRUE	Increase
12057	Repair, intermediate,	Repair of Intermediate	October 2010	22	AAO-HNS,	6.28	Harvard Valued - Utilization ove		February 2010	010	6.00	11.25	5.28	1.07	25	FALSE		FALSE					TRUE	Increase
13100	Repair, complex, trunl	Complex Wound Repair	April 2012	37	AAD, AAO	3.00	CMS Request		July 2011	010	3.00	6.88	2.49	0.36	6,433	FALSE		FALSE					TRUE	Decrease
13101	Repair, complex, trunl	Complex Wound Repair	April 2012	37	AAD, AAO	3.50	CMS Request		July 2011	010	3.50	8.05	3.38	0.39	102,897	FALSE		FALSE					TRUE	Decrease
13102	Repair, complex, trunl	Complex Wound Repair	April 2012	37	AAD, AAO	1.24	CMS Request		July 2011	ZZZ	1.24	2.09	0.68	0.19	26,791	FALSE		FALSE					TRUE	Maintain
13120	Repair, complex, scalp	Complex Wound Repair	October 2017	19	AAD, AAO	3.23	CMS Fastest Growing / CPT Assi		October 2008	010	3.23	7.04	3.22	0.37	12,693	TRUE	1st article: complete	FALSE		September 2018	9	Complete	TRUE	Decrease
13121	Repair, complex, scalp	Complex Wound Repair	October 2017	19	AAD, AAO	4.00	CMS Fastest Growing / CPT Assi		October 2008	010	4.00	8.34	3.08	0.43	207,941	TRUE	1st article: complete	FALSE		September 2018	9	Complete	TRUE	Decrease
13122	Repair, complex, scalp	Complex Wound Repair	October 2017	19	AAD, AAO	1.44	CMS Fastest Growing / CPT Assi		October 2008	ZZZ	1.44	2.18	0.78	0.20	31,342	TRUE	1st article: complete	FALSE		September 2018	9	Complete	TRUE	Maintain
13131	Repair, complex, forel	Complex Wound Repair	April 2012	37	AAD, AAO	3.73	Harvard Valued - Utilization ove		April 2011	010	3.73	7.46	2.90	0.43	41,454	FALSE		FALSE					TRUE	Decrease
13132	Repair, complex, forel	Complex Wound Repair	April 2012	37	AAD, AAO	4.78	CMS Request		September 2011	010	4.78	8.81	3.52	0.49	309,273	FALSE		FALSE					TRUE	Decrease
13133	Repair, complex, forel	Complex Wound Repair	April 2012	37	AAD, AAO	2.19	CMS Request		September 2011	ZZZ	2.19	2.58	1.22	0.26	17,262	FALSE		FALSE					TRUE	Maintain
13150	Repair, complex, eyeli	Complex Wound Repair	April 2012	37	AAD, AAO	Deleted from CPT	CMS Request		September 2011							FALSE		TRUE	Specialties are requesting c	October 2012	05	Deleted fr	TRUE	Deleted from CPT
13151	Repair, complex, eyeli	Complex Wound Repair	April 2012	37	AAD, AAO	4.34	CMS Request		September 2011	010	4.34	7.79	3.26	0.51	33,842	FALSE		FALSE					TRUE	Decrease
13152	Repair, complex, eyeli	Complex Wound Repair	April 2012	37	AAD, AAO	5.34	Harvard Valued - Utilization ove		April 2011	010	5.34	8.93	3.83	0.61	54,926	FALSE		FALSE					TRUE	Decrease
13153	Repair, complex, eyeli	Complex Wound Repair	April 2012	37	AAD, AAO	2.38	CMS Request		July 2011	ZZZ	2.38	2.80	1.28	0.34	938	FALSE		FALSE					TRUE	Maintain
14000	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	ACS, AAD,	6.19	Site of Service Anomaly		April 2008	090	6.37	11.17	7.16	1.03	7,303	FALSE		FALSE					TRUE	Decrease
14001	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	ACS, AAD,	8.58	Site of Service Anomaly		September 2007	090	8.78	13.39	8.68	1.49	9,637	FALSE		FALSE					TRUE	Decrease
14020	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	7.02	Site of Service Anomaly		April 2008	090	7.22	12.29	8.16	0.97	17,817	FALSE		FALSE					TRUE	Decrease
14021	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	9.52	Site of Service Anomaly / CMS F		September 2007	090	9.72	14.29	9.54	1.25	19,350	FALSE		FALSE					TRUE	Decrease
14040	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	8.44	Site of Service Anomaly		April 2008	090	8.60	12.51	8.42	1.03	67,406	FALSE		FALSE					TRUE	Maintain
14041	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	10.63	Site of Service Anomaly		September 2007	090	10.83	14.84	9.98	1.25	45,011	FALSE		FALSE					TRUE	Decrease
14060	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	Maintain	Site of Service Anomaly		April 2008	090	9.23	12.12	8.93	1.04	90,113	FALSE		FALSE					TRUE	Maintain
14061	Adjacent tissue transf	Skin Tissue Rearrangem	October 2008	9	AAD, ASPS	11.25	Site of Service Anomaly		September 2007	090	11.48	16.18	10.86	1.34	31,224	FALSE		FALSE					TRUE	Decrease
14300	Deleted from CPT	Adjacent Tissue Transfe	April 2009	04	ACS, AAD,	Deleted from CPT	Site of Service Anomaly / CMS F		September 2007							FALSE		TRUE	The specialty society comn	February 2009	09	Code Dele	TRUE	Deleted from CPT
14301	Adjacent tissue transf	Adjacent Tissue Transfe	April 2009	04	ACS, AAO-	12.47	Site of Service Anomaly / CMS F		September 2007	090	12.65	17.28	10.74	1.90	38,864	FALSE		FALSE		February 2009	09		TRUE	Decrease
14302	Adjacent tissue transf	Adjacent Tissue Transfe	April 2009	04	ACS, AAO-	3.73	Site of Service Anomaly / CMS F		September 2007	ZZZ	3.73	1.96	1.96	0.64	40,086	FALSE		FALSE		February 2009	09		TRUE	Decrease
15002	Surgical preparation o	RAW	September 2014	21	ASPS	Maintain work RVU and adju	Pre-Time Analysis		January 2014	000	3.65	6.16	2.17	0.64	24,066	FALSE		FALSE					TRUE	Maintain
15004	Surgical preparation o	RAW	September 2014	21	ASPS, APN	Maintain work RVU and adju	Pre-Time Analysis		January 2014	000	4.58	6.61	2.44	0.64	32,464	FALSE		FALSE					TRUE	Maintain
15100	Split-thickness autogr	RAW	September 2014	21	ASPS	Maintain work RVU and adju	Pre-Time Analysis		January 2014	090	9.90	13.91	9.16	1.88	13,549	FALSE		FALSE					TRUE	Maintain
15120	Split-thickness autogr	Autograft	September 2007	16	AAO-HNS,	Remove from screen	Site of Service Anomaly		September 2007	090	10.15	13.24	8.42	1.59	9,650	FALSE		FALSE					TRUE	Remove from Screen
15170	Acellular dermal repla	Acellular Dermal Replac	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE					TRUE	Deleted from CPT
15171	Acellular dermal repla	Acellular Dermal Replac	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE					TRUE	Deleted from CPT
15175	Acellular dermal repla	Acellular Dermal Replac	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		October 2009							FALSE		TRUE	The specialty recommende	October 2010	07	Complete	TRUE	Deleted from CPT
15176	Acellular dermal repla	Acellular Dermal Replac	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE					TRUE	Deleted from CPT
15220	Full thickness graft, fr	Skin Graft	September 2007	16	AAO-HNS,	Reduce 99238 to 0.5	Site of Service Anomaly (99238-		September 2007	090	8.09	13.42	8.53	1.10	9,947	FALSE		FALSE					TRUE	PE Only
15240	Full thickness graft, fr	RAW	September 2014	21	ASPS, AAD	Maintain work RVU and adju	Pre-Time Analysis		January 2014	090	10.41	15.47	11.30	1.35	13,328	FALSE		FALSE					TRUE	Maintain
15271	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	1.50	Different Performing Specialty f		April 2011	000	1.50	2.83	0.73	0.22	111,779	FALSE		FALSE		February 2011			TRUE	Decrease
15272	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	0.59	Different Performing Specialty f		April 2011	ZZZ	0.33	0.36	0.12	0.05	14,569	FALSE		FALSE		February 2011			TRUE	Decrease
15273	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	3.50	Different Performing Specialty f		April 2011	000	3.50	5.22	1.67	0.64	5,775	FALSE		FALSE		February 2011			TRUE	Decrease
15274	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	0.80	Different Performing Specialty f		April 2011	ZZZ	0.80	1.48	0.36	0.16	25,402	FALSE		FALSE		February 2011			TRUE	Decrease
15275	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	1.83	Different Performing Specialty f		April 2011	000	1.83	2.68	0.72	0.19	122,551	FALSE		FALSE		February 2011			TRUE	Decrease
15276	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	0.59	Different Performing Specialty f		April 2011	ZZZ	0.50	0.40	0.17	0.06	6,340	FALSE		FALSE		February 2011			TRUE	Decrease
15277	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	4.00	Different Performing Specialty f		April 2011	000	4.00	5.53	1.89	0.70	1,720	FALSE		FALSE		February 2011			TRUE	Decrease
15278	Application of skin sut	Chronic Wound Dermal	April 2011	04	ACS, APM/	1.00	Different Performing Specialty f		April 2011	ZZZ	1.00	1.65	0.46	0.20	2,936	FALSE		FALSE		February 2011			TRUE	Decrease
15320	Deleted from CPT	Skin Allograft	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		October 2009							FALSE		TRUE	The specialty recommende	October 2010	07	Complete	TRUE	Deleted from CPT
15321	Deleted from CPT	Skin Allograft	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE					TRUE	Deleted from CPT
15330	Acellular dermal allog	Allograft	February 2008	S	ASPS	Deleted from CPT	High IWPUT		February 2008							FALSE		FALSE					TRUE	Deleted from CPT
15331	Deleted from CPT	Acellular Dermal Allogra	February 2010	31	AAO-HNS,	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE					TRUE	Deleted from CPT
15335	Deleted from CPT	Acellular Dermal Allogra	February 2010	31	AAO-HNS,	Deleted from CPT	Different Performing Specialty f		October 2009							FALSE		TRUE	The specialty recommende	October 2010	07	Complete	TRUE	Deleted from CPT
15336	Deleted from CPT	Acellular Dermal Allogra	February 2010	31	AAO-HNS,	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE		February 2011			TRUE	Deleted from CPT
15360	Deleted from CPT	Tissue Cultured Allogen	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE		February 2011			TRUE	Deleted from CPT
15361	Deleted from CPT	Tissue Cultured Allogen	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE		February 2011			TRUE	Deleted from CPT
15365	Deleted from CPT	Tissue Cultured Allogen	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		October 2009							FALSE		TRUE	The specialty recommende	October 2010	07	Complete	TRUE	Deleted from CPT
15366	Deleted from CPT	Tissue Cultured Allogen	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE		February 2011			TRUE	Deleted from CPT
15400	Deleted from CPT	Xenograft	September 2007	16	APMA, AA	Deleted from CPT	Site of Service Anomaly		September 2007							FALSE		FALSE					TRUE	Deleted from CPT
15401	Deleted from CPT	Xenograft	February 2008	S	ACS, ASPS	Deleted from CPT	High Volume Growth	1	February 2008							FALSE		FALSE					TRUE	Deleted from CPT
15420	Deleted from CPT	Xenograft Skin	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		October 2009							FALSE		TRUE	The specialty recommende	October 2010	07	Complete	TRUE	Deleted from CPT
15421	Deleted from CPT	Xenograft Skin	February 2010	31	APMA, ASI	Deleted from CPT	Different Performing Specialty f		February 2010							FALSE		FALSE		February 2011			TRUE	Deleted from CPT
15570	Formation of direct or	Skin Pedicle Flaps	October 2008	10	ACS, ASPS,	10.00	Site of Service Anomaly		September 2007	090	10.21	14.85	9.36	1.85	292	FALSE		FALSE					TRUE	Maintain
15572	Formation of direct or	Skin Pedicle Flaps	October 2008	10	ACS, ASPS,	9.94	Site of Service Anomaly		April 2008	090	10.12	14.00	9.64	1.69	691	FALSE		FALSE					TRUE	Maintain
15574	Formation of direct or	Skin Pedicle Flaps	October 2008	10	ASPS, AAO	10.52	Site of Service Anomaly		September 2007	090	10.70	13.68	9.34	1.45	1,483	FALSE		FALSE					TRUE	Maintain
15576	Formation of direct or	Skin Pedicle Flaps	October 2008	10	ASPS, AAO	9.24	Site of Service Anomaly		September 2007	090	9.37	12.76	8.61	1.13	4,346	FALSE		FALSE					TRUE	Maintain
15730	Midface flap (ie, zygor	Muscle Flaps	January 2017	05	AAO	13.50	High Level E/M in Global Period		January 2017	090	13.50	28.61	11.48	1.67	1,767	FALSE		FALSE					TRUE	Decrease
15732	Muscle, myocutaneou	Muscle Flaps	January 2017	05	ASPS	Deleted from CPT	Site of Service Anomaly / High L		September 2007							FALSE		TRUE	The specialty society expla	September 2016	15	yes	TRUE	Deleted from CPT
15733	Muscle, myocutaneou	Muscle Flaps	January 2017	05	ASPS	15.68	High Level E/M in Global Period		January 2017	090	15.68	NA	12.20	2.36	5,657	FALSE		FALSE					TRUE	Decrease

15734	Muscle, myocutaneou	Muscle Flaps	April 2016	14					23.00	High Level E/M in Global Period	October 2015	090	23.00	NA	16.46	4.72	24,232	FALSE			FALSE		September 2016	15	yes	TRUE	Increase				
15736	Muscle, myocutaneou	Muscle Flaps	April 2016	14				ASSH, ASP	17.04	High Level E/M in Global Period	January 2016	090	17.04	NA	15.54	3.20	1,501	FALSE			FALSE		September 2016	15	yes	TRUE	Maintain				
15738	Muscle, myocutaneou	Muscle Flaps	April 2016	14				ASPS	19.04	High Level E/M in Global Period	January 2016	090	19.04	NA	15.12	3.52	6,218	FALSE			FALSE		September 2016	15	yes	TRUE	Maintain				
15740	Flap; island pedicle re	Dermatology and Plasti	April 2008	28				AAD, ASPS	11.57	Site of Service Anomaly / CMS F	September 2007	090	11.80	15.93	10.87	1.67	2,046	FALSE			TRUE	CPT code 15740 was identi	February 2009 & Fe	11 & 07	Complete	TRUE	Maintain				
15769	Grafting of autologou	Tissue Grafting Proced	October 2018	04	April 2022	RAW		AAOHNS, A	6.68. Flagged for RAW review	Site of Service Anomaly - 2017	May 2018	090	6.68	NA	6.24	1.15		FALSE			FALSE					FALSE	Increase				
15771	Grafting of autologou	Tissue Grafting Proced	October 2018	04				ASPS	6.73	Site of Service Anomaly - 2017	May 2018	090	6.73	8.97	6.08	1.15		FALSE			FALSE					TRUE	Increase				
15772	Grafting of autologou	Tissue Grafting Proced	October 2018	04				ASPS	2.50	Site of Service Anomaly - 2017	May 2018	ZZZ	2.50	2.34	1.15	0.43		FALSE			FALSE					TRUE	Increase				
15773	Grafting of autologou	Tissue Grafting Proced	October 2018	04				ASPS	6.83	Site of Service Anomaly - 2017	May 2018	090	6.83	9.01	6.12	1.15		FALSE			FALSE					TRUE	Increase				
15774	Grafting of autologou	Tissue Grafting Proced	October 2018	04				ASPS	2.41	Site of Service Anomaly - 2017	May 2018	ZZZ	2.41	2.30	1.11	0.41		FALSE			FALSE					TRUE	Increase				
15777	Implantation of biolog	Chronic Wound Dermal	April 2011	04				ACS, APM/	3.65	Different Performing Specialty f	April 2011	ZZZ	3.65	1.97	1.97	0.68	8,429	FALSE			FALSE		February 2011			TRUE	Decrease				
15778		Anterior Abdominal He	April 2021	09				ACS, ASCR	8.00	Site of Service Anomaly - 2019	February 2021							FALSE			FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease				
15823	Blepharoplasty, upper	Upper Eyelid Blepharop	April 2010	33				AAO	6.81	Harvard Valued - Utilization ove	October 2009	090	6.81	10.71	8.60	0.59	97,994	FALSE			FALSE					TRUE	Decrease				
16020	Dressings and/or debr	Dressings/ Debridemen	October 2010	08				ASPS, AAF	0.80	Different Performing Specialty f	October 2009	000	0.71	1.66	0.77	0.13	15,272	FALSE			FALSE					TRUE	Maintain				
16025	Dressings and/or debr	Dressings/ Debridemen	October 2010	08				ASPS, AAF	1.85	Different Performing Specialty f	October 2009	000	1.74	2.58	1.22	0.26	1,908	FALSE			FALSE					TRUE	Maintain				
16030	Dressings and/or debr	Dressings/ Debridemen	April 2010	45				ACEP, ASP	CPT Assistant article publishe	Different Performing Specialty f	February 2010	000	2.08	3.28	1.38	0.37	879	TRUE	Oct 2012	Yes	FALSE					TRUE	Maintain				
17000	Destruction (eg, laser	Destruction of Premalig	April 2013	17				AAD	0.61	MPC List	October 2010	010	0.61	1.27	0.90	0.05	6,117,793	FALSE			FALSE					TRUE	Decrease				
17003	Destruction (eg, laser	Destruction of Premalig	April 2013	17				AAD	0.04	Low Value-Billed in Multiple Un	October 2010	ZZZ	0.04	0.15	0.02	0.00	19,474,499	FALSE			FALSE					TRUE	Decrease				
17004	Destruction (eg, laser	Destruction of Premalig	April 2013	17				AAD	Remove from Modifier -51 Ex	CMS High Expenditure Procedur	September 2011	010	1.37	3.35	1.34	0.13	874,685	FALSE			FALSE					TRUE	Decrease				
17106	Destruction of cutane	Destruction of Skin Lesi	October 2008	11				AAD	3.61	High IWPUT	February 2008	090	3.69	5.92	3.87	0.39	3,933	FALSE			FALSE					TRUE	Decrease				
17107	Destruction of cutane	Destruction of Skin Lesi	October 2008	11				AAD	4.68	High IWPUT	February 2008	090	4.79	7.74	5.00	0.56	1,449	FALSE			FALSE					TRUE	Decrease				
17108	Destruction of cutane	Destruction of Skin Lesi	October 2008	11				AAD	6.37	High IWPUT	February 2008	090	7.49	10.10	6.78	0.92	5,081	FALSE			FALSE					TRUE	Decrease				
17110	Destruction (eg, laser	RAW	October 2013	18					Remove from screen	High Volume Growth2	April 2013	010	0.70	2.57	1.15	0.06	2,556,286	FALSE			FALSE					TRUE	Remove from Screen				
17111	Destruction (eg, laser	RAW	October 2013	18					Remove from screen	High Volume Growth2	April 2013	010	0.97	2.84	1.29	0.09	122,909	FALSE			FALSE					TRUE	Remove from screen				
17250	Chemical cauterizatio	RAW	October 2019	17	January 2022	RAW		AAFP, ACS	Review in 2 years (Jan 2022).	High Volume Growth3	October 2015	000	0.50	2.07	0.50	0.06	234,080	TRUE	Sep 2016	Yes	TRUE	In January 2016, the Relati	September 2016	17	yes	FALSE				
17261	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	1.22	Harvard Valued - Utilization ove	October 2009	010	1.22	3.00	1.17	0.13	140,325	FALSE			FALSE					TRUE	Maintain				
17262	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	1.63	Harvard Valued - Utilization ove	February 2010	010	1.63	3.45	1.40	0.15	287,333	FALSE			FALSE					TRUE	Maintain				
17271	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	1.54	Harvard Valued - Utilization ove	February 2010	010	1.54	3.18	1.35	0.15	53,690	FALSE			FALSE					TRUE	Maintain				
17272	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	1.82	Harvard Valued - Utilization ove	February 2010	010	1.82	3.54	1.51	0.17	82,281	FALSE			FALSE					TRUE	Maintain				
17281	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	1.77	Harvard Valued - Utilization ove	February 2010	010	1.77	3.33	1.48	0.16	86,818	FALSE			FALSE					TRUE	Maintain				
17282	Destruction, malignan	Destruction of Malignar	October 2010	26				AAD, AAFF	2.09	Harvard Valued - Utilization ove	October 2009	010	2.09	3.74	1.66	0.21	81,831	FALSE			FALSE					TRUE	Maintain				
17311	Mohs micrographic te	Mohs Surgery	April 2013	18				AAD	6.20	CMS High Expenditure Procedur	September 2011	000	6.20	12.99	3.57	0.59	829,586	FALSE			FALSE					TRUE	Maintain				
17312	Mohs micrographic te	Mohs Surgery	April 2013	18				AAD	3.30	CMS High Expenditure Procedur	September 2011	ZZZ	3.30	8.41	1.89	0.31	509,267	FALSE			FALSE					TRUE	Maintain				
17313	Mohs micrographic te	Mohs Surgery	April 2013	18				AAD	5.56	CMS High Expenditure Procedur	January 2012	000	5.56	12.49	3.20	0.52	140,796	FALSE			FALSE					TRUE	Maintain				
17314	Mohs micrographic te	Mohs Surgery	April 2013	18				AAD	3.06	CMS High Expenditure Procedur	January 2012	ZZZ	3.06	8.16	1.76	0.28	57,990	FALSE			FALSE					TRUE	Maintain				
17315	Mohs micrographic te	Mohs Surgery	April 2013	18				AAD	0.87	CMS High Expenditure Procedur	January 2012	ZZZ	0.87	1.30	0.50	0.09	19,946	FALSE			FALSE					TRUE	Maintain				
19020	Mastotomy with explo	Mastotomy	September 2007	16				ACS	Reduce 99238 to 0.5, remove	Site of Service Anomaly	September 2007	090	3.83	9.57	4.50	0.86	1,614	FALSE			FALSE					TRUE	PE Only				
19081	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	3.29	Codes Reported Together 75% c	January 2012	000	3.29	13.26	1.19	0.32	60,561	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19082	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	1.65	Codes Reported Together 75% c	January 2012	ZZZ	1.65	11.70	0.60	0.16	4,476	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19083	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	3.10	Codes Reported Together 75% c	January 2012	000	3.10	13.47	1.12	0.32	118,588	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19084	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	1.55	Codes Reported Together 75% c	January 2012	ZZZ	1.55	11.57	0.56	0.15	15,269	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19085	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	3.64	Codes Reported Together 75% c	January 2012	000	3.64	22.01	1.32	0.30	5,634	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19086	Biopsy, breast, with pl	Breast Biopsy	April 2013	04				ACR, ACS,	1.82	Codes Reported Together 75% c	January 2012	ZZZ	1.82	18.59	0.66	0.15	1,195	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19102	Biopsy of breast; perc	Breast Biopsy	April 2013	04				ACR, ACS,	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE			FALSE		October 2012	08	Complete	TRUE	Deleted from CPT				
19103	Biopsy of breast; perc	Breast Biopsy	April 2013	04				ACR, ACS,	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE			FALSE		October 2012	08	Complete	TRUE	Deleted from CPT				
19281	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	2.00	Codes Reported Together 75% c	January 2012	000	2.00	5.08	0.72	0.16	30,514	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19282	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	1.00	Codes Reported Together 75% c	January 2012	ZZZ	1.00	4.08	0.36	0.09	3,292	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19283	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	2.00	Codes Reported Together 75% c	January 2012	000	2.00	5.80	0.72	0.20	3,526	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19284	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	1.00	Codes Reported Together 75% c	January 2012	ZZZ	1.00	4.98	0.36	0.13	338	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19285	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	1.70	Codes Reported Together 75% c	January 2012	000	1.70	10.83	0.62	0.15	25,714	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19286	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	0.85	Codes Reported Together 75% c	January 2012	ZZZ	0.85	9.77	0.31	0.09	2,002	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19287	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	3.02	Codes Reported Together 75% c	January 2012	000	2.55	19.02	0.92	0.21	266	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19288	Placement of breast lo	Breast Biopsy	April 2013	04				ACR, ACS,	1.51	Codes Reported Together 75% c	January 2012	ZZZ	1.28	15.82	0.46	0.11	60	FALSE			FALSE		October 2012	08	Complete	TRUE	Decrease				
19290	Preoperative placeme	Breast Biopsy	April 2013	04				ACR, ACS,	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE			FALSE		October 2012	08	Complete	TRUE	Deleted from CPT				
19291	Preoperative placeme	Breast Biopsy	April 2013	04				ACR, ACS,	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE			FALSE		October 2012	08	Complete	TRUE	Deleted from CPT				
19295	Image guided placeme	Breast Biopsy	April 2013	04				ACR, ACS,	Deleted from CPT	CMS Fastest Growing / Codes R	October 2008							FALSE			FALSE		October 2012	08	Complete	TRUE	Deleted from CPT				
19303	Mastectomy, simple, c	Mastectomy	April 2016	15				ACS, ASBS	15.00	Site of Service Anomaly - 2015 /	October 2015	090	15.00	NA	9.73	3.60	24,587	FALSE			FALSE					TRUE	Decrease				
19307	Mastectomy, modifiec	Modified Radical Maste	January 2020	22					17.99	Site of Service Anomaly - 2019	October 2019	090	17.99	NA	12.69	4.33	6,042	FALSE			FALSE					TRUE	Decrease				
19318	Breast reduction	Mammaplasty	September 2007	16				ASPS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	16.03	NA	13.22	2.89	7,501	FALSE			FALSE					TRUE	PE Only				
19340	Insertion of breast im	Breast Implant/Expand	January 2020	05				ASPS	11.00	CMS Request / Site of Service Ar	October 2009	090	10.48	NA	9.81	1.94	7,433	FALSE			FALSE					TRUE	Decrease				
19357	Tissue expander place	Breast Implant/Expand	January 2020	05				ASPS	15.36	Site of Service Anomaly / 090-D	September 2007	090	14.84	NA	16.67	2.69	6,479	FALSE			TRUE	Originally referred to CPT b	October 2009	20	Complete	TRUE	Decrease				
20000	Deleted from CPT	Incision of Abcess	September 2007	16				APMA, AA	Deleted from CPT	Site of Service Anomaly (99238-	September 2007							FALSE			TRUE	This service was identified	June 2009	15	Code Dele	TRUE	Deleted from CPT				
20005	Incision and drainage	Incision of Deep Absces	October 2017	19				ACS, AAO-	Deleted from CPT	Site of Service Anomaly / Negat	September 2007							FALSE			TRUE	A RUC member requested	February 2018	06	complete	TRUE	Deleted from CPT				
20220	Biopsy, bone, trocar, c	Bone Biopsy Trocar/Ne	January 2019	22				ACR, SIR	1.93	Different Performing Specialty f	January 2018	000	1.65	5.58	0.75	0.15	12,355	FALSE			FALSE					TRUE	Increase				
20225	Biopsy, bone, trocar, c	Bone Biopsy Trocar/Ne	January 2019	22				ACR, SIR	3.00	Different Performing Specialty f	October 2017	000	2.45	9.49	1.11	0.22	14,341	FALSE			FALSE					TRUE	Increase				
20240	Biopsy, bone, open; s	Bone Biopsy Excisional	January 2016	04				AAOS, APN	3.73	010-Day Global Post-Operative \	April 2014	000	2.61	NA	1.25	0.31	6,533	FALSE			FALSE					TRUE	Increase				
20245	Biopsy, bone, open; d	Bone Biopsy Excisional	January 2016	04				AAOS	6.50	010-Day Global Post-Operative \	January 2014	000	6.00	NA	3.17	1.02	4,354	FALSE			TRUE	In April 2015, in preparatio	October 2015		revised	TRUE	Decrease				
20525	Removal of foreign bo	Removal of Foreign Boc	September 2007	16				ACS, AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	010	3.54	10.08	3.09	0.63	1,693	FALSE			FALSE					TRUE	PE Only				
20526	Injection, therapeutic	RAW	January 2017	30					Remove fromm screen	CMS 000-Day Global Typically Ra	July 2016	000	0.94	1.27	0.57	0.16	102,673	FALSE			FALSE					TRUE	Remove from Screen				
20550	Injection(s); single ter	Injection of Tendon	January 2016	27		RUC		AAOS, AAF	0.75	CMS Fastest Growing / CMS Hig	October 2008	000	0.75	0.80	0.30	0.09	848,059	FALSE			FALSE					TRUE	Maintain				
20551	Injection(s); single ter	Therapeutic Injection C	April 2017	10				AAPMR, A	0.75	CMS Fastest Growing / CMS 000	October 2008	000	0.75	0.84	0.31	0.09	163,234	FALSE			FALSE					TRUE	Maintain				
20552	Injection(s); single or multiple trigger point(s)		January 2016	28		RUC		AAPM&R,	0.66	CMS High Expenditure Procedur	July 2015	000	0.66	0.84	0.36	0.09	350,677	FALSE			FALSE					TRUE	Maintain				
20553	Injection(s); single or multiple trigger point(s)		January 2016	28		RUC		AAPM&R,	0.75	CMS High Expenditure Procedur	July 2015	000	0.75	0.98	0.41	0.09	378,100	FALSE			FALSE					TRUE	Maintain				
20600	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	0.66 and new PE inputs	Harvard Valued - Utilization ove	February 2010	000	0.66	0.77	0.30	0.09	444,325	FALSE			TRUE	Ultrasound as an imaging t	October 2013	06	Complete	TRUE	Maintain				
20604	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	0.89	CMS Request - Final Rule for 20	July 2013	000	0.89	1.38	0.36	0.10	46,354	FALSE			FALSE		October 2013	06		TRUE	Decrease				
20605	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	0.68 and new PE inputs	Harvard Valued - Utilization ove	October 2009	000	0.68	0.81	0.32	0.09	466,622	FALSE			TRUE	Ultrasound as an imaging t	October 2013	06	Complete	TRUE	Maintain				
20606	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	1.00	CMS Request - Final Rule for 20	July 2013	000	1.00	1.47	0.42	0.13	56,334	FALSE			FALSE		October 2013	06		TRUE	Decrease				
20610	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	0.79 and new PE inputs	Harvard Valued - Utilization ove	February 2010	000	0.79	0.96	0.42	0.13	6,722,382	FALSE			TRUE	Ultrasound as an imaging t	October 2013	06	Complete	TRUE	Maintain				
20611	Arthrocentesis, aspira	Arthrocentesis	January 2014	04				AAFP, AAC	1.10	CMS Request - Final Rule for 20	July 2013	000	1.10	1.65	0.51	0.15	1,069,935	FALSE			FALSE		October 2013	06		TRUE	Decrease				
20612	Aspiration and/or inje	RAW	January 2017	30					Remove from screen	CMS 000-Day Global Typically Ra	July 2016	000	0.70	1.06	0.41	0.10	28,400	FALSE			FALSE					TRUE	Remove from Screen				
20680	Removal of implant; d	RAW	September 2014	21				AAOS, APN	5.96 and adjustments to pre-	Pre-Time Analysis	January 2014	090	5.96	11.22	5.36	1.02	55,761	FALSE			FALSE					TRUE	Maintain				
20692	Application of a multi	RAW	April 2014	52					Maintain	090-Day Global Post-Operative \	January 2014	090	16.27	NA	13.87	2.76	3,150	FALSE			FALSE					TRUE	Maintain				
20694	Removal, under anest	External Fixation	September 2007	16				AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	4.28	7.72	4.95	0.75	6,209	FALSE			FALSE					TRUE	PE Only				
20700	Manual preparation a	Drug Delivery Implant P	October 2018	05				AAOS, AU/	1.50	Different Performing Specialty f	May 2018	ZZZ	1.50	0.68	0.68	0.26		FALSE			FALSE					TRUE	Increase				
20701	Removal of drug-deliv	Drug Delivery Implant P	October 2018	05				AAOS, AU/	1.13	Different Performing Specialty f	May 2018	ZZZ	1.13	0.51	0.51	0.21		FALSE			FALSE					TRUE	Increase				
20702	Manual preparation a	Drug Delivery Implant P	October 2018	05				AAOS, AU/	2.50	Different Performing Specialty f	May 2018	ZZZ	2.50	1.14	1.14	0.45		FALSE			FALSE					TRUE	Increase				
20703	Removal of drug-deliv	Drug Delivery Implant P	October 2018	05				AAOS, AU/	1.80	Different Performing Specialty f	May 2018	ZZZ	1.80	0.82	0.82	0.32		FALSE			FALSE					TRUE	Increase				
20704	Manual preparation a	Drug Delivery Implant P	October 2018	05				AAOS, AU/	2.60	Different Performing Specialty f	May 2018	ZZZ	2.60	1.19	1.19	0.47		FALSE			FALSE					TRUE	Increase				
20705	Removal of drug-deliv	Drug Delivery Implant P	October 2018	05				AAOS, AU/	2.15	Different Performing Specialty f	May 2018	ZZZ	2.15	0.98	0.98	0.39		FALSE			FALSE					TRUE	Increase				
20900	Bone graft, any donor	Bone Graft Procedures	April 2008	29				AOFAS, AA	3.00	Site of Service Anomaly	September 2007	000	3.00	8.60	1.85	0.51	4,436	FALSE			FALSE					TRUE	Decrease				
20902	Bone graft, any donor	Bone Graft Procedures	April 2008	29				AOFAS, AA	4.58	Site of Service Anomaly	April 2008	000	4.58	NA	2.76	0.85	4,599	FALSE			FALSE					TRUE	Decrease				
20926	Tissue grafts, other (e	Tissue Grafting Proced	October 2018	04				AAOS, ASP	Deleted from CPT	CMS Fastest Growing / Site of Se	October 2008						14,815	TRUE	Deleted fo	N/A	TRUE	In October 2017, AMA Staf	May 2018	12	Yes	TRUE	Deleted from CPT				
21015	Radical resection of tu	Radical Resection of So	February 2009	6				ACS, AAOS	9.71	Site of Service Anomaly	September 2007	090	9.89	NA	9.04	1.66	506	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Increase				
21025	Excision of bone (eg, f	Excision of Bone – Man	October 2010	61				AAOMS	10.03	Site of Service Anomaly	September 2007	090	10.03	12.52	8.55	0.95	3,614	FALSE			FALSE					TRUE	Decrease				
21495	Open treatment of hy	Laryngoplasty	January 2016	09		RUC			Deleted from CPT	090-Day Global Post-Operative \	October 2015							FALSE			FALSE					TRUE	Deleted from CPT				
21557	Radical resection of tu	Radical Resection of So	February 2009	6				ACS, AAOS	14.57	Site of Service Anomaly	September 2007	090	14.75	NA	10.39	2.91	490	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Decrease				
21800	Closed treatment of ri	Internal Fixation of Rib	April 2014	05				STS, ACS	Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE			TRUE	Refer to CPT for deletion. T	February 2014	15	Complete	TRUE	Deleted from CPT				
21805	Open treatment of rib	Internal Fixation of Rib	April 2014	05				STS, ACS	Deleted from CPT	CMS Request - Final Rule for 20	January 2014							FALSE			TRUE	Referred to CPT for deletio	October 2014	7	Complete	TRUE	Deleted from CPT				

21810	Treatment of rib fract	Internal Fixation of Rib	April 2014	05			STS, ACS	Deleted from CPT	CMS Request - Final Rule for 20	January 2014							FALSE			FALSE		October 2013	07	Complete	TRUE	Deleted from CPT
21811	Open treatment of rib	Internal Fixation of Rib	April 2014	05			STS, ACS	19.55	CMS Request - Final Rule for 20	January 2014	000	10.79	NA	4.31	2.36	357	FALSE			FALSE		October 2013	07	Complete	TRUE	Decrease
21812	Open treatment of rib	Internal Fixation of Rib	April 2014	05			STS, ACS	25.00	CMS Request - Final Rule for 20	January 2014	000	13.00	NA	5.32	2.82	468	FALSE			FALSE		October 2013	07	Complete	TRUE	Decrease
21813	Open treatment of rib	Internal Fixation of Rib	April 2014	05			STS, ACS	35.00	CMS Request - Final Rule for 20	January 2014	000	17.61	NA	7.08	4.32	62	FALSE			FALSE		October 2013	07	Complete	TRUE	Decrease
21820	Closed treatment of s	Internal Fixation of Rib	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	CMS Request - Final Rule for 20	January 2014	090	1.36	2.76	2.69	0.26	190	TRUE	Jan 2018	yes	FALSE		October 2013	07	Complete	TRUE	PE Only
21825	Open treatment of ste	Internal Fixation of Rib	April 2014	05			STS, ACS	Unrelated to the family	CMS Request - Final Rule for 20	January 2014	090	7.76	NA	6.59	1.74	737	FALSE			FALSE		October 2013	07	Complete	TRUE	Remove from screen
21935	Radical resection of tu	Radical Resection of So	February 2009	6			ACS, AAOS	15.54	Site of Service Anomaly	September 2007	090	15.72	NA	11.11	3.42	235	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Decrease
22214	Osteotomy of spine, p	RAW	September 2014	21			AAOS, NA	Maintain	CMS Fastest Growing	October 2008	090	21.02	NA	17.74	5.74	6,695	FALSE			FALSE					TRUE	Maintain
22305	Closed treatment of v	Closed treatment of ver	April 2015	23			AANS/CNS	Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE			TRUE	In October 2013, AAOS and	May 2016	13	Complete	TRUE	Deleted from CPT
22310	Closed treatment of v	Closed Treatment Verte	January 2020	23	October 2023	RAW	AANS, AA	3.45. Flag for Rereview	Negative IWPUT / Site of Servic	April 2017	090	3.45	4.93	4.53	0.74	6,942	FALSE			FALSE					FALSE	Decrease
22510	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	8.15	Codes Reported Together 75% c	April 2014	010	7.90	47.52	3.71	0.97	3,686	FALSE			FALSE	Joint Workgroup recomme	February 2014	16	Complete	TRUE	Decrease
22511	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	8.05	Codes Reported Together 75% c	April 2014	010	7.33	47.95	3.58	0.92	4,104	FALSE			FALSE		February 2014	16	Complete	TRUE	Decrease
22512	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	4.00	Codes Reported Together 75% c	April 2014	ZZZ	4.00	19.83	1.42	0.61	2,505	FALSE			FALSE		February 2014	16	Complete	TRUE	Decrease
22513	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	8.90	Codes Reported Together 75% c	April 2014	010	8.65	185.14	4.81	1.53	24,396	FALSE			FALSE		February 2014	16	Complete	TRUE	Decrease
22514	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	8.24	Codes Reported Together 75% c	April 2014	010	7.99	185.16	4.57	1.44	26,776	FALSE			FALSE		February 2014	16	Complete	TRUE	Decrease
22515	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	4.00	Codes Reported Together 75% c	April 2014	ZZZ	4.00	100.20	1.68	0.74	15,688	FALSE			FALSE		February 2014	16	Complete	TRUE	Decrease
22520	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	CMS Request - Practice Expense	February 2009							FALSE			TRUE	Joint Workgroup recomme	February 2014	16	Complete	TRUE	Deleted from CPT
22521	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	Site of Service Anomaly (99238-	September 2007							FALSE			TRUE	Joint Workgroup recomme	February 2014	16	Complete	TRUE	Deleted from CPT
22522	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	Codes Reported Together 75% c	April 2014							FALSE			FALSE		February 2014	16	Complete	TRUE	Deleted from CPT
22523	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	CMS Request: PE Review	September 2011							FALSE			FALSE		February 2014	16	Complete	TRUE	Deleted from CPT
22524	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	CMS Request: PE Review	September 2011							FALSE			FALSE		February 2014	16	Complete	TRUE	Deleted from CPT
22525	Percutaneous vertebr	Percutaneous Vertebro	April 2014	06			AANS, CN	Deleted from CPT	CMS Request: PE Review	September 2011							FALSE			FALSE		February 2014	16	Complete	TRUE	Deleted from CPT
22533	Arthrodesis, lateral ex	Arthrodesis	September 2011	51			AAOS, NA	Remove from screen. CPT As	CMS Fastest Growing	October 2008	090	24.79	NA	18.10	5.96	908	TRUE	Oct 2009	Yes	FALSE					TRUE	Remove from Screen
22551	Arthrodesis, anterior i	Arthrodesis	February 2010	05			NASS, AAN	24.50	Codes Reported Together 95% c	February 2010	090	25.00	NA	17.59	7.64	40,145	FALSE			FALSE		October 2009	21		TRUE	Decrease
22552	Arthrodesis, anterior i	Arthrodesis	February 2010	05			NASS, AAN	6.50	Codes Reported Together 95% c	February 2010	ZZZ	6.50	NA	3.20	1.94	35,696	FALSE			FALSE		October 2009	21		TRUE	Maintain
22554	Arthrodesis, anterior i	Arthrodesis	February 2010	5			NASS, AAN	17.69	Codes Reported Together 95% c	February 2008	090	17.69	NA	14.17	5.27	4,675	FALSE			TRUE	Referred to the CPT Editori	October 2009	21	Complete	TRUE	Maintain
22558	Arthrodesis, anterior i	Vertebral Corpectomy v	January 2017	30	October 2022	RAW	AANS/CNS	Review action plan and addit	High Volume Growth2 / Codes F	April 2013	090	23.53	NA	15.54	6.05	20,376	FALSE			TRUE	In January 2015 the Joint C	September 2016	20	yes	FALSE	
22585	Arthrodesis, anterior i	Arthrodesis	February 2010	05			NASS, AAN	Remove from screen	Codes Reported Together 95% c	February 2010	ZZZ	5.52	NA	2.57	1.50	17,132	FALSE			FALSE		October 2009	21		TRUE	Maintain
22612	Arthrodesis, posterior	Lumbar Arthrodesis	October 2015	21			AANS/CNS	Review utilization data Octot	Codes Reported Together 75% c	February 2010	090	23.53	NA	16.98	6.31	44,894	FALSE			TRUE	The Workgroup accepts th	October 2010	16	Complete	TRUE	Maintain
22614	Arthrodesis, posterior	Lumbar Arthrodesis	February 2011	04			AANS/CNS	6.43	Codes Reported Together 75% c	February 2010	ZZZ	6.43	NA	3.19	1.88	144,296	FALSE			FALSE					TRUE	Decrease
22630	Arthrodesis, posterior	Lumbar Arthrodesis	February 2011	04			AANS/CNS	22.09	Codes Reported Together 75% c	February 2010	090	22.09	NA	17.38	7.12	5,654	FALSE			TRUE	The Workgroup accepts th	October 2010	16	Complete	TRUE	Maintain
22632	Arthrodesis, posterior	Lumbar Arthrodesis	February 2011	04			AANS/CNS	5.22	Codes Reported Together 75% c	February 2010	ZZZ	5.22	NA	2.56	1.63	1,875	FALSE			FALSE					TRUE	Decrease
22633	Arthrodesis, combine	Lumbar Arthrodesis	February 2011	04			AANS/CNS	27.75	Codes Reported Together 75% c	February 2010	090	27.75	NA	18.89	7.96	38,096	FALSE			TRUE		October 2010	16	Complete	TRUE	Decrease
22634	Arthrodesis, combine	Lumbar Arthrodesis	February 2011	04			AANS/CNS	8.16	Codes Reported Together 75% c	February 2010	ZZZ	8.16	NA	4.04	2.37	14,338	FALSE			TRUE		October 2010	16	Complete	TRUE	Decrease
22843	Posterior segmental ir	Spine Fixation Device	February 2009	38			AAOS, NA	Remove from screen	CMS Fastest Growing	October 2008	ZZZ	13.44	NA	6.67	3.87	8,692	FALSE			FALSE					TRUE	Remove from Screen
22849	Reinsertion of spinal f	RAW	September 2014	21			AAOS, NA	Maintain	CMS Fastest Growing	October 2008	090	19.17	NA	14.05	5.38	4,231	FALSE			TRUE	The Workgroup recommen	June 2010	10	Complete	TRUE	Maintain
22851	Application of interve	Biomechancial Device In	January 2016	06		RUC	AANS/CNS	Deleted from CPT	CMS Fastest Growing / High Vol	October 2008							FALSE			TRUE	While preparing to survey t	October 2015	14	Code Dele	TRUE	Deleted from CPT
22859	Insertion of interverte	Biomechancial Device In	January 2016	06			AAOS, AA	6.00	CMS High Expenditure Procedur	October 2015	ZZZ	5.50	NA	2.72	1.59	1,934	FALSE			FALSE					TRUE	Decrease
22867	Insertion of interlamir	Insertion of Interlamina	January 2021	26			AAOS, AA	15.00	CMS High Expenditure Procedur	October 2015	090	13.50	NA	11.54	4.02	2,131	FALSE			FALSE					TRUE	Increase
22868	Insertion of interlamir	Biomechancial Device In	January 2016	06			AAOS, AA	5.50	CMS High Expenditure Procedur	October 2015	ZZZ	4.00	NA	1.96	1.25	532	FALSE			FALSE					TRUE	Decrease
22900	Excision, tumor, soft t	Subfascial Excision of Sc	February 2009	5			ACS, AAOS	8.21	Site of Service Anomaly	September 2007	090	8.32	NA	6.48	1.89	628	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Increase
23076	Excision, tumor, soft t	Subfascial Excision of Sc	February 2009	5			ACS, AAOS	7.28	Site of Service Anomaly	September 2007	090	7.41	NA	7.02	1.57	677	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Decrease
23120	Claviculectomy; partia	Claviculectomy	April 2008	30			AAOS	7.23	Site of Service Anomaly	September 2007	090	7.39	NA	8.52	1.46	6,767	FALSE			FALSE					TRUE	Maintain
23130	Acromioplasty or acro	Removal of Bone	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	7.77	NA	8.95	1.55	1,826	FALSE			FALSE					TRUE	PE Only
23350	Injection procedure fc	Injection for Shoulder X	September 2011	13			ACR, AAOS	1.00	Harvard Valued - Utilization ove	April 2011	000	1.00	3.80	0.37	0.09	35,070	FALSE			FALSE					TRUE	Maintain
23405	Tenotomy, shoulder a	Tenotomy	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	8.54	NA	8.24	1.53	2,277	FALSE			FALSE					TRUE	PE Only
23410	Repair of ruptured mu	Rotator Cuff	February 2008	12			AAOS	11.23	Site of Service Anomaly	September 2007	090	11.39	NA	10.61	2.22	3,333	FALSE			FALSE					TRUE	Decrease
23412	Repair of ruptured mu	Rotator Cuff	September 2014	21			AAOS	Maintain work RVU and adju	Site of Service Anomaly / Pre-Ti	September 2007	090	11.93	NA	10.91	2.32	12,002	FALSE			FALSE					TRUE	Decrease
23415	Coracoacromial ligam	Shoulder Ligament Rele	October 2010	62			AAOS	9.23	Site of Service Anomaly	September 2007	090	9.23	NA	9.58	1.82	408	FALSE			FALSE					TRUE	Decrease
23420	Reconstruction of con	Rotator Cuff	February 2008	12			AAOS	13.35	Site of Service Anomaly	September 2007	090	13.54	NA	12.52	2.68	2,359	FALSE			FALSE					TRUE	Decrease
23430	Tenodesis of long ten	Tenodesis	October 2009	12			AAOS	10.17	CMS Fastest Growing, Site of Se	September 2007	090	10.17	NA	9.89	1.93	19,997	FALSE			FALSE					TRUE	Maintain
23440	Resection or transplar	Tendon Transfer	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	10.64	NA	9.61	2.10	1,487	FALSE			FALSE					TRUE	PE Only
23472	Arthroplasty, glenohu	Arthroplasty	October 2015	21			AAOS	Remove from screen	CMS Fastest Growing / High Vol	October 2008	090	22.13	NA	16.29	4.25	67,382	FALSE			FALSE					TRUE	Remove from Screen
23540	Closed treatment of a	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	2.36	4.19	4.11	0.46	339	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23600	Closed treatment of p	Treatment of Humerus	September 2011	14			AAOS	3.00	Harvard Valued - Utilization ove	April 2011	090	3.00	6.32	5.76	0.59	32,747	FALSE			FALSE					TRUE	Decrease
23625	Closed treatment of g	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.10	6.43	5.50	0.79	173	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23650	Closed treatment of sl	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	3.53	5.37	4.47	0.70	14,692	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23655	Closed treatment of sl	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.76	NA	6.41	0.93	2,327	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23665	Closed treatment of sl	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.66	7.24	6.24	0.92	556	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24505	Closed treatment of h	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.39	8.49	6.96	1.07	890	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24600	Treatment of closed e	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.37	5.82	4.78	0.86	1,283	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24605	Treatment of closed e	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.64	NA	7.43	1.10	382	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25116	Radical excision of bur	Forearm Excision	October 2010	63			ASSH, AAC	7.56	Site of Service Anomaly	September 2007	090	7.56	NA	8.89	1.37	1,034	FALSE			FALSE					TRUE	Maintain
25210	Carpectomy; 1 bone	Carpectomy	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	6.12	NA	7.35	1.10	3,150	FALSE			FALSE					TRUE	PE Only
25260	Repair, tendon or mus	Tendon Repair	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	8.04	NA	9.21	1.46	919	FALSE			FALSE					TRUE	PE Only
25280	Lengthening or shorte	Tendon Repair	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	7.39	NA	8.02	1.35	1,402	FALSE			FALSE					TRUE	PE Only
25310	Tendon transplantatic	Forearm Repair	February 2008	15			ASSH, AAC	7.94	Site of Service Anomaly	September 2007	090	8.08	NA	8.81	1.46	7,690	FALSE			FALSE					TRUE	Decrease
25565	Closed treatment of ra	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.85	8.38	6.78	1.15	667	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25605	Closed treatment of d	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	6.25	8.59	7.68	1.24	20,527	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25606	Percutaneous skeletal	RAW	September 2014	21			AAOS, ASS	Maintain work RVU and adju	Pre-Time Analysis	September 2014	090	8.31	NA	9.77	1.62	2,015	FALSE			FALSE					TRUE	Maintain
25607	Open treatment of dis	RAW	September 2014	21			AAOS, ASS	Maintain work RVU and adju	Pre-Time Analysis	September 2014	090	9.56	NA	10.43	1.82	9,419	FALSE			FALSE					TRUE	Maintain
25608	Open treatment of dis	RAW	September 2014	21			AAOS, ASS	Maintain work RVU and adju	Pre-Time Analysis	September 2014	090	11.07	NA	11.23	2.10	7,290	FALSE			FALSE					TRUE	Maintain
25609	Open treatment of dis	RAW	September 2014	21			AAOS, ASS	Maintain work RVU and adju	Pre-Time Analysis	January 2014	090	14.38	NA	13.92	2.68	18,114	FALSE			FALSE					TRUE	Maintain
25675	Closed treatment of d	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.89	7.39	6.10	0.96	445	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26020	Drainage of tendon sh	Tendon Sheath Procedu	April 2018	07			AAOS, ASP	7.79	Negative IWPUT	April 2017	090	6.84	NA	8.34	1.25	2,453	FALSE			FALSE					TRUE	Increase
26055	Tendon sheath incisio	Tendon Sheath Procedu	April 2018	07			AAOS, ASP	3.75	Negative IWPUT	April 2017	090	3.11	13.80	4.93	0.58	105,433	FALSE			FALSE					TRUE	Increase
26080	Arthrotomy, with expl	RAW	October 2015	21		RAW	ASSH, AAC	Action plan for RAW Oct 201	Site of Service Anomaly / CPT As	September 2007	090	4.47	NA	6.50	0.79	1,997	TRUE	Sep 2012	Yes	FALSE					TRUE	Maintain
26160	Excision of lesion of te	Tendon Sheath Procedu	April 2018	07			AAOS, ASP	3.57	Negative IWPUT	April 2017	090	3.57	13.97	5.13	0.64	18,598	FALSE			FALSE					TRUE	Maintain
26356	Repair or advancemer	Repair Flexor Tendon	April 2015	25		RUC	AAOS, ASP	10.03	Site of Service Anomaly (99238-	September 2007	090	9.56	NA	12.28	1.73	1,150	FALSE			FALSE					TRUE	Decrease
26357	Repair or advancemer	Repair Flexor Tendon	April 2015	25		RUC	AAOS, ASP	11.50	090-Day Global Post-Operative '	April 2014	090	11.00	NA	13.25	2.21	66	FALSE			FALSE					TRUE	Increase
26358	Repair or advancemer	Repair Flexor Tendon	April 2015	25		RUC	AAOS, ASP	13.10	090-Day Global Post-Operative '	April 2014	090	12.60	NA	14.08	2.53	42	FALSE			FALSE					TRUE	Increase
26480	Transfer or transplant	Tendon Transfer	April 2009	26			AAOS, ASS	6.76	CMS Fastest Growing	October 2008	090	6.90	NA	15.38	1.24	10,824	FALSE			FALSE					TRUE	Maintain
26700	Closed treatment of m	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	3.83	5.38	4.61	0.74	471	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26750	Closed treatment of d	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	1.80	3.40	3.43	0.34	6,976	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26755	Closed treatment of d	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	3.23	5.67	4.32	0.63	522	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26770	Closed treatment of ir	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	3.15	4.68	3.93	0.61	5,900	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27048	Excision, tumor, soft t	Excision of Subfascial Sc	February 2009	05			ACS, AAOS	8.74	Site of Service Anomaly	September 2007	090	8.85	NA	7.31	1.91	339	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Increase
27062	Excision; trochanteric	Trochanteric Bursa Exci	April 2008	32			AAOS	5.66	Site of Service Anomaly	September 2007	090	5.75	NA	6.60	1.13	1,884	FALSE			FALSE					TRUE	Maintain
27096	Injection procedure fc	Injection for Sacroiliac J	April 2011	06			AAPM, AA	1.48	Different Performing Specialty f	October 2009	000	1.48	3.26	0.81	0.14	489,612	FALSE			TRUE	Refer to CPT Editorial Pane	February 2011	76	Code Revis	TRUE	Decrease
27130	Arthroplasty, acetabul	Hip/Knee Arthroplasty	October 2019	11			AAOS, AA	19.60	CMS High Expenditure Procedur	September 2011	090	19.60	NA	14.40	3.90	169,584	FALSE			FALSE					TRUE	Decrease
27134	Revision of total hip a	RAW	September 2014	21			AAOS, AA	Maintain work RVU and adju	Pre-Time Analysis	January 2014	090	30.28	NA	19.86	6.01	10,863	FALSE			FALSE					TRUE	Maintain
27193	Closed treatment of p	Closed Treatment of Pe	January 2016	07			AAOS	Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE			TRUE	Refer to CPT for deletion. T	October 2015		Code Dele	TRUE	Deleted from CPT
27194	Closed treatment of p	Closed Treatment of Pe	January 2016	07			AAOS	Deleted from CPT	CMS Request - Final Rule for 20	October 2015							FALSE			FALSE				Code Dele	TRUE	Deleted from CPT
27197	Closed treatment of p	Closed Treatment of Pe	January 2016	07			AAOS	5.50	CMS Request - Final Rule for 20	October 2015	000	1.53	NA	2.07	0.30	11,080	FALSE			FALSE					TRUE	Decrease
27198	Closed treatment of p	Closed Treatment of Pe	January 2016	07			AAOS	9.00	CMS Request - Final Rule for 20	October 2015	000	4.75	NA	3.74	0.86	206	FALSE			FALSE					TRUE	Decrease
27220	Closed treatment of a	Closed Treatment Fract	April 2018	08			AAOS	6.00	Negative IWPUT	April 2017	090	5.50	5.78	5.61	1.10	3,070	FALSE			FALSE					TRUE	Decrease
27230	Closed treatment of fe	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.81	7.43	7.17	1.15	1,509	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only

27232	Closed treatment of fe	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	11.72	NA	7.83	2.32	194	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27236	Open treatment of fe	Open Treatment of Fen	October 2012	16			AAOS	17.61	CMS High Expenditure Procedur	September 2011	090	17.61	NA	14.10	3.47	57,280	FALSE			FALSE							TRUE	Maintain
27240	Closed treatment of ir	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	13.81	NA	11.78	2.74	260	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27244	Treatment of intertro	Treat Thigh Fracture	October 2008	12			AAOS	18.00	High IWPUT	April 2008	090	18.18	NA	14.43	3.60	5,947	FALSE			FALSE							TRUE	Increase
27245	Treatment of intertro	Treat Thigh Fracture	October 2008	12			AAOS	18.00	High IWPUT / CMS Fastest Grow	February 2008	090	18.18	NA	14.41	3.58	83,430	FALSE			FALSE							TRUE	Decrease
27250	Closed treatment of h	Closed Treatment of Hi	February 2008	18			ACEP	3.82	Site of Service Anomaly	September 2007	000	3.82	NA	0.73	0.75	3,180	FALSE			FALSE							TRUE	Decrease
27252	Closed treatment of h	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	11.03	NA	9.11	2.21	762	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27265	Closed treatment of p	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.24	NA	5.75	1.03	8,333	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27266	Closed treatment of p	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	7.78	NA	7.98	1.53	5,456	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27279	Arthrodesis, sacroiliac	Arthodesis - Sacroiliac J	April 2018	09			AANS, AAC	9.03	CMS Request - Final Rule for 20	July 2017	090	12.13	NA	10.28	3.04	3,753	FALSE			FALSE							TRUE	Maintain
27324	Biopsy, soft tissue of t	Soft Tissue Biopsy	September 2007	16			ACS, AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	5.04	NA	5.87	1.14	814	FALSE			FALSE							TRUE	PE Only
27369	Injection procedure fo	Knee Arthrography Inje	October 2017	05			ACR	0.96	Harvard Valued - Utilization Ove	June 2017	000	0.77	4.22	0.30	0.10	60,267	FALSE			TRUE	In June 2017, the CPT Editc	February 2018	EC-O	complete	TRUE	Maintain
27370	Injection of contrast fo	Knee Arthrography Inje	October 2017	05			ACR	Deleted from CPT	High Volume Growth1 / CMS Fa	February 2008							TRUE	Clinical Ex	Yes	TRUE	In October 2016, the RUC v	June 2017	09	yes	TRUE	Deleted from CPT
27446	Arthroplasty, knee, co	Knee Arthroplasty	April 2021	18			AAOS, AAH	17.13	CMS High Expenditure Procedur	September 2011	090	17.48	NA	13.11	3.44	15,803	FALSE			FALSE							TRUE	Decrease
27447	Arthroplasty, knee, co	Hip/Knee Arthroplasty	April 2021	18			AAOS, AAH	19.60	CMS High Expenditure Procedur	September 2011	090	19.60	NA	14.37	3.88	312,130	FALSE			FALSE							TRUE	Decrease
27502	Closed treatment of fe	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	11.36	NA	8.76	2.22	385	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27510	Closed treatment of fe	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	9.80	NA	8.41	1.92	386	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27550	Closed treatment of k	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.98	8.46	7.25	1.19	531	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27552	Closed treatment of k	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	8.18	NA	8.95	1.62	269	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27615	Radical resection of tu	Radical Resecion of Soft	February 2009	6			ACS, AAOS	15.54	Site of Service Anomaly	September 2007	090	15.72	NA	11.22	3.20	211	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Increase
27619	Excision, tumor, soft t	Excision of Subfascial Sc	February 2009	5			ACS, AAOS	6.80	Site of Service Anomaly	September 2007	090	6.91	NA	5.54	1.10	552	FALSE			TRUE	CPT developed new coding	June 2008	06	New code	TRUE	Decrease
27640	Partial excision (crate	Leg Bone Resection Par	February 2008	19			AOFAS, AA	12.10	Site of Service Anomaly	September 2007	090	12.24	NA	10.13	2.15	1,673	FALSE			TRUE	CPT Editorial Panel address	June 2008	07	Complete	TRUE	Maintain
27641	Partial excision (crate	Leg Bone Resection Par	February 2008	19			AOFAS, AA	9.72	Site of Service Anomaly	February 2008	090	9.84	NA	7.91	1.59	905	FALSE			TRUE	CPT Editorial Panel address	June 2008	07	Complete	TRUE	Decrease
27650	Repair, primary, open	Achilles Tendon Repair	February 2008	20			AAOS, AOI	9.00	Site of Service Anomaly	September 2007	090	9.21	NA	8.78	1.44	2,516	FALSE			FALSE							TRUE	Decrease
27654	Repair, secondary, Acl	Achilles Tendon Repair	April 2008	33			AOFAS, AP	10.32	Site of Service Anomaly	September 2007	090	10.53	NA	8.89	1.51	3,117	FALSE			FALSE							TRUE	Maintain
27685	Lengthening or shorte	Tendon Repair	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	6.69	12.08	6.05	0.90	4,084	FALSE			FALSE							TRUE	PE Only
27687	Gastrocnemius recess	Tendon Repair	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	6.41	NA	6.02	0.93	7,093	FALSE			FALSE							TRUE	PE Only
27690	Transfer or transplant	Tendon Transfer	April 2008	34			AOFAS, AP	8.96	Site of Service Anomaly	September 2007	090	9.17	NA	8.39	1.35	1,376	FALSE			FALSE							TRUE	Maintain
27691	Transfer or transplant	Tendon Transfer	April 2008	34			AOFAS, AP	10.28	Site of Service Anomaly	September 2007	090	10.49	NA	9.72	1.73	4,579	FALSE			FALSE							TRUE	Maintain
27752	Closed treatment of ti	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	6.27	8.42	7.06	1.25	1,229	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27762	Closed treatment of m	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.47	7.69	6.33	1.03	369	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27792	Open treatment of dis	Treatment of Ankle Fra	February 2011	18			AAOS, AOI	9.71	Site of Service Anomaly	June 2010	090	8.75	NA	8.74	1.59	7,279	FALSE			FALSE							TRUE	Maintain
27810	Closed treatment of b	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	5.32	7.64	6.25	1.03	2,962	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27814	Open treatment of bir	RAW	September 2014	21			AAOS	Maintain work RVU and adju	Pre-Time Analysis	January 2014	090	10.62	NA	10.01	1.98	10,858	FALSE			FALSE							TRUE	Maintain
27818	Closed treatment of ti	Treatment of Fracture	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Site of Service Anomaly (99238-	September 2007	090	5.69	7.71	6.15	1.10	3,490	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27825	Closed treatment of fi	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	6.69	8.17	6.59	1.28	659	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
27840	Closed treatment of a	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	4.77	NA	5.53	0.93	2,234	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
28001	Incision and drainage,	Treatment of Foot Infec	October 2020	14			AAOS, AOI	2.00	010-Day Global Post-Operative	April 2020	010	2.78	5.09	1.87	0.25	3,770	FALSE			FALSE							TRUE	Decrease
28002	Incision and drainage	Treatment of Foot Infec	October 2020	14			AAOS, AOI	3.50	010-Day Global Post-Operative	January 2014	010	5.34	7.01	3.34	0.54	6,661	FALSE			FALSE							TRUE	Decrease
28003	Incision and drainage	Treatment of Foot Infec	October 2020	14			AAOS, AOI	5.28	010-Day Global Post-Operative	April 2020	090	9.06	10.59	6.33	1.02	5,470	FALSE			FALSE							TRUE	Decrease
28111	Ostectomy, complete	Ostectomy	September 2007	16			APMA, AA	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	5.15	8.71	3.71	0.56	1,069	FALSE			FALSE							TRUE	PE Only
28120	Partial excision (crate	Removal of Foot Bone	February 2011	19			AOFAS, AP	8.27	Site of Service Anomaly	September 2007	090	7.31	11.80	6.30	0.96	5,154	FALSE			FALSE							TRUE	Increase
28122	Partial excision (crate	Removal of Foot Bone	February 2011	19			AOFAS, AP	7.72	Site of Service Anomaly	September 2007	090	6.76	10.10	5.30	0.71	14,469	FALSE			FALSE							TRUE	Maintain
28124	Partial excision (crate	Toe Removal	September 2007	16			APMA, AA	Remove 99238	Site of Service Anomaly (99238-	September 2007	090	5.00	8.71	4.25	0.45	11,425	FALSE			FALSE							TRUE	PE Only
28285	Correction, hammertc	Orthopaedic Surgery/Pc	October 2010	31			AAOS, AOI	5.62	Harvard Valued - Utilization ove	February 2010	090	5.62	9.73	4.95	0.56	71,537	FALSE			FALSE							TRUE	Increase
28289	Hallux rigidus correcti	Bunionectomy	January 2016	08			AAOS, AOI	6.90	090-Day Global Post-Operative	October 2015	090	6.90	13.18	5.72	0.75	4,662	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28290	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	Deleted from CPT	090-Day Global Post-Operative	October 2015							FALSE			FALSE		October 2015	19	Complete	TRUE	Deleted from CPT
28291	Hallux rigidus correcti	Bunionectomy	January 2016	08			AAOS, AOI	8.01	090-Day Global Post-Operative	October 2015	090	8.01	12.74	5.60	0.78	4,067	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28292	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	7.44	090-Day Global Post-Operative	October 2015	090	7.44	12.86	5.88	0.71	6,950	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28293	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	Deleted from CPT	090-Day Global Post-Operative	January 2014							FALSE			TRUE	In January 2014, the RUC re	October 2015	19	Complete	TRUE	Deleted from CPT
28294	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	Deleted from CPT	090-Day Global Post-Operative	October 2015							FALSE			FALSE		October 2015	19	Complete	TRUE	Deleted from CPT
28295	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	8.57	090-Day Global Post-Operative	October 2015	090	8.57	23.38	8.29	1.30	586	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28296	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	8.25	Site of Service Anomaly	September 2007	090	8.25	17.86	5.94	0.74	9,559	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28297	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	9.29	090-Day Global Post-Operative	October 2015	090	9.29	20.85	7.24	1.10	2,793	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28298	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	7.75	Site of Service Anomaly (99238-	September 2007	090	7.75	16.46	6.00	0.86	2,903	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28299	Correction, hallux valg	Bunionectomy	January 2016	08			AAOS, AOI	9.29	090-Day Global Post-Operative	October 2015	090	9.29	19.90	6.82	0.99	4,743	FALSE			FALSE		October 2015	19	Complete	TRUE	Decrease
28300	Osteotomy; calcaneus	Osteotomy	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	9.73	NA	7.88	1.51	2,519	FALSE			FALSE							TRUE	PE Only
28310	Osteotomy, shortenin	Osteotomy	September 2007	16			APMA, AA	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	5.57	10.09	4.37	0.62	1,640	FALSE			FALSE							TRUE	PE Only
28470	Closed treatment of m	Treatment of Metatarsa	September 2011	15			AAOS, APN	2.03	Harvard Valued - Utilization ove	April 2011	090	2.03	4.14	3.72	0.28	29,629	FALSE			FALSE							TRUE	Maintain
28660	Closed treatment of ir	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	010	1.28	2.07	1.21	0.22	689	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only
28725	Arthrodesis; subtalar	Foot Arthrodesis	February 2011	20			AOFAS, AP	12.18	Site of Service Anomaly	September 2007	090	11.22	NA	9.84	1.81	4,389	FALSE			FALSE							TRUE	Maintain
28730	Arthrodesis, midtarsal	Foot Arthrodesis	February 2011	20			AOFAS, AP	12.42	Site of Service Anomaly	September 2007	090	10.70	NA	9.25	1.63	3,581	FALSE			FALSE							TRUE	Maintain
28740	Arthrodesis, midtarsal	Arthrodesis	September 2007	16			AAOS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	9.29	14.18	7.58	1.25	3,996	FALSE			FALSE							TRUE	PE Only
28820	Amputation, toe; met	Toe Amputation	April 2019	11			AAOS, ACS	4.10	Site of Service Anomaly - 2018	October 2018	000	3.51	5.16	1.34	0.44	30,702	FALSE			FALSE							TRUE	Decrease
28825	Amputation, toe; inter	Toe Amputation	April 2019	11			AAOS, ACS	4.00	Site of Service Anomaly	September 2007	000	3.41	5.09	1.30	0.42	15,013	FALSE			FALSE							TRUE	Decrease
29075	Application, cast; elbo	Application of Forearm	September 2011	16			AAOS, ASS	0.77	Harvard Valued - Utilization ove	April 2011	000	0.77	1.62	0.90	0.15	68,396	FALSE			FALSE							TRUE	Maintain
29105	Application of long arı	Application of Long Arn	April 2017	11			AAOS, ACE	0.80	CMS 000-Day Global Typically R	July 2016	000	0.80	1.45	0.29	0.15	25,626	FALSE			FALSE							TRUE	Decrease
29200	Strapping; thorax	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	April 2013	000	0.39	0.56	0.13	0.02	13,693	FALSE			FALSE							TRUE	Decrease
29220	Deleted from CPT	Strapping; low back	April 2008	57			AAFP	Deleted from CPT	High Volume Growth1	February 2008							TRUE	Deleted fr	Yes	TRUE	The specialty society was u	October 2008	10	Code Dele	TRUE	Deleted from CPT
29240	Strapping; shoulder (e	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	April 2013	000	0.39	0.49	0.13	0.02	16,307	FALSE			FALSE							TRUE	Decrease
29260	Strapping; elbow or w	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	October 2013	000	0.39	0.45	0.14	0.04	5,004	FALSE			FALSE							TRUE	Decrease
29280	Strapping; hand or fin	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	October 2013	000	0.39	0.43	0.14	0.04	3,404	FALSE			FALSE							TRUE	Decrease
29445	Application of rigid to	Application of Rigid Leg	April 2016	17			AAOS, AHI	1.78	High Volume Growth3	October 2015	000	1.78	1.78	0.94	0.21	36,431	FALSE			FALSE							TRUE	Maintain
29520	Strapping; hip	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	April 2013	000	0.39	0.64	0.13	0.02	13,018	FALSE			FALSE							TRUE	Decrease
29530	Strapping; knee	Strapping Procedures	January 2014	35			APTA	0.39	High Volume Growth2	April 2013	000	0.39	0.48	0.12	0.02	27,045	FALSE			FALSE							TRUE	Decrease
29540	Strapping; ankle and/c	Strapping Lower Extrem	April 2017	41ii			APMA	0.39	Harvard Valued - Utilization ove	October 2009	000	0.39	0.39	0.09	0.04	213,060	FALSE			FALSE							TRUE	Decrease
29550	Strapping; toes	Strapping Lower Extrem	April 2017	41ii			APMA	0.25	Harvard Valued - Utilization ove	February 2010	000	0.25	0.28	0.06	0.02	56,200	FALSE			FALSE							TRUE	Decrease
29580	Strapping; Unna boot	Strapping Multi Layer C	October 2016	13		RUC	ACS, APM/	0.55	CMS High Expenditure Procedur	July 2015	000	0.55	1.26	0.16	0.06	265,752	FALSE			FALSE							TRUE	Maintain
29581	Application of multi-la	Strapping Multi Layer C	October 2016	13			ACS, APM/	0.60	CMS High Expenditure Procedur	July 2015	000	0.60	2.03	0.18	0.02	194,064	FALSE			FALSE							TRUE	Maintain
29582	Application of multi-la	New Technology Reviev	October 2015	21			APTA	Deleted from CPT	New Technology/New Services	October 2015							TRUE	Aug 2016	Yes	FALSE		September 2016	22	yes	TRUE	Deleted from CPT
29583	Application of multi-la	New Technology Reviev	October 2015	21			APTA	Deleted from CPT	New Technology/New Services	October 2015							TRUE	Aug 2016	Yes	FALSE		September 2016	22	yes	TRUE	Deleted from CPT
29584	Application of multi-la	New Technology Reviev	October 2018	27	January 2022	RAW	APTA	Develop CPT Assistant Article	New Technology/New Services ,	October 2015	000	0.35	2.12	0.10	0.01	2,715	TRUE	Aug 2016	Yes	FALSE					FALSE	
29590	Denis-Browne splint s	Dennis-Browne splint re	April 2012	07			APMA	Deleted from CPT	Harvard Valued - Utilization ove	February 2010							FALSE			TRUE	This service was identified	February 2012	08	Code Dele	TRUE	Deleted from CPT
29805	Arthroscopy, shoulder	Arthroscopy	April 2008	51			AAOS	No NF PE inputs	CMS Request - Practice Expense	NA	090	6.03	NA	6.74	1.16	698	FALSE			FALSE							TRUE	PE Only
29822	Arthroscopy, shoulder	Shoulder Debridement	January 2020	11				7.03	CMS Fastest Growing	October 2008	090	7.03	NA	7.61	1.39	9,153	FALSE			TRUE	In October 2018, AMA staf	September 2019	14	yes	TRUE	Decrease
29823	Arthroscopy, shoulder	Shoulder Debridement	January 2020	11				7.98	Harvard-Valued Annual Allowed	October 2012	090	7.98	NA	8.03	1.52	45,349	FALSE			TRUE	In October 2018, AMA staf	September 2019	14	yes	TRUE	Decrease
29824	Arthroscopy, shoulder	RAW	October 2015	21			AAOS	8.82	Codes Reported Together 75% c	February 2010	090	8.98	NA	9.29	1.73	39,895	FALSE			FALSE							TRUE	Maintain
29826	Arthroscopy, shoulder	RAW	October 2015	21			AAOS	3.00	Codes Reported Together 75% c	February 2010	ZZZ	3.00	NA	1.52	0.59	78,655	FALSE			FALSE							TRUE	Decrease
29827	Arthroscopy, shoulder	RAW	October 2015	21			AAOS	15.59. Maintain work RVU an	CMS Fastest Growing/ Codes Re	October 2008	090	15.59	NA	12.97	2.98	69,465	FALSE			FALSE							TRUE	Maintain
29828	Arthroscopy, shoulder	RAW	October 2015	21			AAOS	13.16	Codes Reported Together 75% c	February 2010	090	13.16	NA	11.38	2.53	18,992	FALSE			FALSE							TRUE	Maintain
29830	Arthroscopy, elbow, d	Arthroscopy	April 2008	51			AAOS	No NF PE inputs	CMS Request - Practice Expense	NA	090	5.88	NA	6.50	1.00	136	FALSE			FALSE							TRUE	PE Only
29840	Arthroscopy, wrist, dia	Arthroscopy	April 2008	51			AAOS	No NF PE inputs	CMS Request - Practice Expense	NA	090	5.68	NA	6.66	1.02	125	FALSE			FALSE							TRUE	PE Only
29870	Arthroscopy, knee, dia	Arthroscopy	October 2009	13			AAOS	New PE non-facility inputs	CMS Request - Practice Expense	NA	090	5.19	10.58	5.85	0.97	1,031	FALSE			FALSE							TRUE	PE Only
29888	Arthroscopically aidec	ACL Repair	April 2008	38			AAOS	14.14	Site of Service Anomaly	September 2007	090	14.30	NA	11.84	2.70	1,173	FALSE			FALSE							TRUE	Maintain
29900	Arthroscopy, metacarp	Arthroscopy	April 2008	51			AAOS	No NF PE inputs	CMS Request - Practice Expense	NA	090	5.88	NA	7.79	1.17	4	FALSE			FALSE							TRUE	PE Only
30140	Submucous resection	Resection of Inferior Tu	October 2016	14		RUC	AAOHNS	3.00	Harvard Valued - Utilization ove	October 2015	000	3.00	5.28	1.75	0.43	49,954	FALSE			FALSE							TRUE	Decrease
30465	Repair of nasal vestibı	Repair Nasal Stenosis	September 2007	16			AAO-HNS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	12.36	NA	16.15	1.73	4,626	FALSE			FALSE							TRUE	PE Only

30901	Control nasal hemorrh	Control Nasal Hemorrha	April 2016	20			AAOHNS	1.10		Harvard Valued - Utilization ove	October 2009	000	1.10	3.36	0.37	0.17	88,372	FALSE			FALSE						TRUE	Maintain		
30903	Control nasal hemorrh	Control Nasal Hemorrha	April 2016	20			AAOHNS	1.54		CMS Request - Final Rule for 20	July 2015	000	1.54	5.49	0.47	0.26	48,496	FALSE			FALSE						TRUE	Maintain		
30905	Control nasal hemorrh	Control Nasal Hemorrha	April 2016	20			AAOHNS	1.97		CMS Request - Final Rule for 20	July 2015	000	1.97	8.29	0.78	0.34	5,245	FALSE			FALSE						TRUE	Maintain		
30906	Control nasal hemorrh	Control Nasal Hemorrha	April 2016	20			AAOHNS	2.45		CMS Request - Final Rule for 20	July 2015	000	2.45	8.13	1.14	0.36	800	FALSE			FALSE						TRUE	Maintain		
31231	Nasal endoscopy, diag	Nasal/Sinus Endoscopy	January 2012	19			AAO-HNS	1.10		MPC List	October 2010	000	1.10	4.54	0.61	0.15	660,545	FALSE			FALSE						TRUE	Maintain		
31237	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	April 2013	19			AAO-HNS	2.60		CMS High Expenditure Procedur	September 2011	000	2.60	4.56	1.65	0.36	137,754	FALSE			FALSE						TRUE	Decrease		
31238	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	April 2013	19			AAO-HNS	2.74		CMS High Expenditure Procedur	January 2012	000	2.74	4.25	1.71	0.38	29,505	FALSE			FALSE						TRUE	Decrease		
31239	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	April 2013	19			AAO-HNS	9.04		CMS High Expenditure Procedur	January 2012	010	9.04	NA	7.80	0.93	1,366	FALSE			FALSE						TRUE	Decrease		
31240	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	April 2013	19			AAO-HNS	2.61		CMS High Expenditure Procedur	January 2012	000	2.61	NA	1.62	0.36	6,458	FALSE			FALSE						TRUE	Maintain		
31241	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	8.51		Codes Reported Together 75% c	April 2015	000	8.00	NA	3.78	1.10	470	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31253	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	9.00		Codes Reported Together 75% c	April 2015	000	9.00	NA	4.26	1.25	8,502	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31254	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	4.27		CMS Request - Final Rule for 20	July 2015	000	4.27	8.03	2.19	0.59	13,255	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31255	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	5.75		Codes Reported Together 75% c	April 2015	000	5.75	NA	2.84	0.78	11,287	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31256	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	3.11		CMS Request - Final Rule for 20	July 2015	000	3.11	NA	1.68	0.43	15,592	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31257	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	8.00		Codes Reported Together 75% c	April 2015	000	8.00	NA	3.83	1.10	5,920	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31259	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	8.48		Codes Reported Together 75% c	April 2015	000	8.48	NA	4.04	1.17	7,903	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31267	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	4.68		CMS Request - Final Rule for 20	July 2015	000	4.68	NA	2.36	0.64	28,703	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31276	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	6.75		Codes Reported Together 75% c	April 2015	000	6.75	NA	3.27	0.93	15,859	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31287	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	3.50		Codes Reported Together 75% c	April 2015	000	3.50	NA	1.84	0.48	3,280	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31288	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	4.10		Codes Reported Together 75% c	April 2015	000	4.10	NA	2.11	0.58	4,121	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31295	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	2.70		Codes Reported Together 75% c	April 2015	000	2.70	52.30	1.50	0.37	28,533	FALSE			FALSE						TRUE	Maintain		
31296	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	3.10		Codes Reported Together 75% c	April 2015	000	3.10	52.59	1.67	0.43	8,725	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31297	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	January 2017	07			AAOHNS	2.44		Codes Reported Together 75% c	April 2015	000	2.44	52.17	1.38	0.34	2,120	FALSE			TRUE	In April 2015, the Joint CPT	September 2016	24	yes		TRUE	Decrease		
31298	Nasal/sinus endoscop	Nasal/Sinus Endoscopy	October 2020	24			AAOHNS	4.50		Codes Reported Together 75% c	April 2015	000	4.50	99.88	2.28	0.63	19,499	FALSE			FALSE		September 2016	24	yes		TRUE	Decrease		
31500	Intubation, endotrach	Endotracheal Intubatio	October 2018	27			ACEP, ASA	3.00		CMS High Expenditure Procedur	July 2015	000	3.00	NA	0.72	0.43	263,123	TRUE	Oct 2016	yes	FALSE						TRUE	Increase		
31551	Laryngoplasty; for lary	Laryngoplasty	January 2016	09			AAOHNS	21.50		090-Day Global Post-Operative '	October 2015	090	21.50	NA	20.58	2.95	2	FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31552	Laryngoplasty; for lary	Laryngoplasty	January 2016	09			AAOHNS	20.50		090-Day Global Post-Operative '	October 2015	090	20.50	NA	20.16	2.81	12	FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31553	Laryngoplasty; for lary	Laryngoplasty	January 2016	09			AAOHNS	22.00		090-Day Global Post-Operative '	October 2015	090	22.00	NA	24.58	3.03		FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31554	Laryngoplasty; for lary	Laryngoplasty	January 2016	09			AAOHNS	22.00		090-Day Global Post-Operative '	October 2015	090	22.00	NA	24.60	3.03	23	FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31571	Laryngoscopy, direct, '	Laryngoscopy	September 2007	16			AAO-HNS	Reduce 99238 to 0.5		Site of Service Anomaly (99238-	September 2007	000	4.26	NA	2.32	0.59	5,271	FALSE			FALSE						TRUE	PE Only		
31575	Laryngoscopy, flexible; diagnostic		October 2015	08			AAO-HNS	1.00		MPC List / CMS High Expenditur	October 2010	000	0.94	2.69	0.87	0.13	658,434	FALSE			FALSE						TRUE	Decrease		
31579	Laryngoscopy, flexible	Laryngoscopy	October 2015	08			AAO-HNS	1.94		CMS Fastest Growing / CMS Hig	October 2008	000	1.88	3.65	1.31	0.25	86,928	FALSE			FALSE						TRUE	Decrease		
31580	Laryngoplasty; for lary	Laryngoplasty	January 2016	09			AAO-HNS	14.60		090-Day Global Post-Operative '	April 2014	090	14.60	NA	21.35	1.99	21	FALSE			TRUE	CPT code 31588 was identi	October 2015	13	Complete		TRUE	Decrease		
31582	Laryngoplasty; for lary	Laryngoplasty	January 2015	09			AAO-HNS	Deleted from CPT		090-Day Global Post-Operative '	April 2014							FALSE			TRUE	CPT code 31588 was identi	October 2015	13	Deleted fr		TRUE	Deleted from CPT		
31584	Laryngoplasty; with o	Laryngoplasty	January 2016	09			AAO-HNS	20.00		090-Day Global Post-Operative '	April 2014	090	17.58	NA	21.83	2.42	15	FALSE			TRUE	CPT code 31588 was identi	October 2015	13	Complete		TRUE	Decrease		
31587	Laryngoplasty, cricoid	Laryngoplasty	January 2016	09			AAO-HNS	15.27		090-Day Global Post-Operative '	April 2014	090	15.27	NA	17.87	2.10	15	FALSE			TRUE	CPT code 31588 was identi	October 2015	13	Complete		TRUE	Decrease		
31588	Laryngoplasty, not oth	Laryngoplasty	January 2016	09			AAO-HNS	Deleted from CPT		090-Day Global Post-Operative '	January 2014							FALSE			TRUE	CPT code 31588 was identi	October 2015	13	Deleted fr		TRUE	Deleted from CPT		
31591	Laryngoplasty, medial	Laryngoplasty	January 2016	09			AAOHNS	15.60		090-Day Global Post-Operative '	October 2015	090	13.56	NA	16.65	1.88	1,148	FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31592	Cricotracheal resectio	Laryngoplasty	January 2016	09			AAOHNS	25.00		090-Day Global Post-Operative '	October 2015	090	25.00	NA	22.15	3.43	23	FALSE			FALSE		October 2015	13	Complete		TRUE	Decrease		
31600	Tracheostomy, planne	Tracheostomy	April 2016	21			AAOHNS	5.56		CMS High Expenditure Procedur	July 2015	000	5.56	NA	2.38	1.03	23,498	FALSE			FALSE						TRUE	Increase		
31601	Tracheostomy, planne	Tracheostomy	April 2016	21			AAOHNS	8.00		CMS High Expenditure Procedur	July 2015	000	8.00	NA	3.93	1.10	4	FALSE			FALSE						TRUE	Increase		
31603	Tracheostomy, emerg	Tracheostomy	April 2016	21			AAOHNS	6.00		CMS High Expenditure Procedur	July 2015	000	6.00	NA	2.34	1.03	801	FALSE			FALSE						TRUE	Increase		
31605	Tracheostomy, emerg	Tracheostomy	April 2016	21			AAOHNS	6.45		CMS High Expenditure Procedur	July 2015	000	6.45	NA	2.02	1.26	278	FALSE			FALSE						TRUE	Increase		
31610	Tracheostomy, fenest	Tracheostomy	October 2016	15	RUC		AAOHNS, /	12.00		CMS High Expenditure Procedur	July 2015	090	12.00	NA	14.66	1.76	1,593	FALSE			FALSE						TRUE	Increase		
31611	Construction of trache	Speech Prosthesis	February 2008	S			AAO-HNS	Reduce 99238 to 0.5		Site of Service Anomaly	September 2007	090	6.00	NA	9.01	0.82	761	FALSE			FALSE						TRUE	PE Only		
31620	Endobronchial ultraso	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	Deleted from CPT		High Volume Growth2	April 2013							FALSE			TRUE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Deleted from CPT		
31622	Bronchoscopy, rigid or	Bronchial Aspiration of	January 2015	05			ACCP, ATS	2.78		High Volume Growth2	April 2013	000	2.53	4.51	1.03	0.27	52,315	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Maintain		
31623	Bronchoscopy, rigid or	Diagnostic Bronchoscop	October 2017	09			ATS, CHES	2.63		High Volume Growth4	October 2016	000	2.63	5.36	1.01	0.21	26,278	FALSE			FALSE						TRUE	Maintain		
31624	Bronchoscopy, rigid or	Diagnostic Bronchoscop	October 2017	09			ATS, CHES	2.63		High Volume Growth4	October 2017	000	2.63	4.74	1.04	0.22	118,565	FALSE			FALSE						TRUE	Maintain		
31625	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ATS, CHES	3.36		High Volume Growth2	April 2013	000	3.11	7.16	1.17	0.26	19,149	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Maintain		
31626	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	4.16		High Volume Growth2	April 2013	000	3.91	21.01	1.42	0.43	2,173	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Maintain		
31628	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	3.80		High Volume Growth2	April 2013	000	3.55	7.37	1.30	0.26	32,291	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Maintain		
31629	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	4.00		High Volume Growth2	April 2013	000	3.75	9.78	1.36	0.31	13,745	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Decrease		
31632	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	1.03		High Volume Growth2	April 2013	ZZZ	1.03	0.77	0.32	0.09	3,890	FALSE			FALSE						TRUE	Maintain		
31633	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ACCP, ATS	1.32		High Volume Growth2	April 2013	ZZZ	1.32	0.93	0.42	0.11	1,196	FALSE			FALSE						TRUE	Maintain		
31645	Bronchoscopy, rigid or	Bronchial Aspiration of	October 2016	08	RUC		ATS, CHES	2.88		Harvard Valued - Utilization ove	October 2015	000	2.88	4.90	1.13	0.26	35,233	FALSE			FALSE		May 2016	14	Complete		TRUE	Decrease		
31646	Bronchoscopy, rigid or	Bronchial Aspiration of	October 2016	08	RUC		ATS, CHES	2.78		Harvard Valued - Utilization ove	October 2015	000	2.78	NA	1.09	0.25	4,580	FALSE			FALSE		May 2016	14	Complete		TRUE	Increase		
31652	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ATS, ACCP	5.00		High Volume Growth2	October 2014	000	4.46	32.45	1.59	0.42	25,507	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Decrease		
31653	Bronchoscopy, rigid or	Endobronchial Ultrasou	January 2015	05			ATS, ACCP	5.50		High Volume Growth2	October 2014	000	4.96	33.33	1.74	0.45	13,988	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Decrease		
31654	Bronchoscopy, rigid or	Bronchial Aspiration of	January 2015	05			ATS, ACCP	1.70		High Volume Growth2	October 2014	ZZZ	1.40	2.12	0.44	0.11	8,214	FALSE			FALSE	In January 2014, the RUC re	October 2014	10	Complete		TRUE	Decrease		
32201	Pneumonostomy; with	Drainage of Abscess	January 2013	04				Deleted from CPT		Codes Reported Together 75% c	January 2012							FALSE			FALSE	Deleted nine codes that de	October 2012	06	Complete		TRUE	Deleted from CPT		
32405	Biopsy, lung or media	Lung Biopsy-CT Guidan	April 2019	05			ACR, SIR	Deleted from CPT		Codes Reported Together 75%o	October 2017						70,068	FALSE			TRUE	In October 2017, maintaini	February 2019	11	complete		TRUE	Deleted from CPT		
32408	Core needle biopsy, lu	Lung Biopsy-CT Guidan	April 2019	05			ACR, SIR	4.00		Codes Reported Together 75%o	April 2019	000	3.18	24.27	1.00	0.26		FALSE			FALSE						TRUE	Increase		
32420	Pneumocentesis, punc	Thoracentesis with Tub	September 2011	17			ACCP, ACR	Deleted from CPT		Harvard Valued - Utilization ove	September 2011							FALSE			TRUE	In September 2011, the spe	February 2012	10	Complete		TRUE	Deleted from CPT		
32421	Thoracentesis, punctu	Thoracentesis with Tub	September 2011	17			ACCP, ACR	Deleted from CPT		Harvard Valued - Utilization ove	September 2011							FALSE			TRUE	In September 2011, the spe	February 2012	10	Complete		TRUE	Deleted from CPT		
32422	Thoracentesis with ins	Thoracentesis with Tub	September 2011	17			ACCP, ACR	Deleted from CPT		Harvard Valued - Utilization ove	April 2011							FALSE			TRUE	In September 2011, the spe	February 2012	10	Complete		TRUE	Deleted from CPT		
32440	Removal of lung, pneu	RAW Review	January 2013	34			ACCP, ATS	No reliable way to determine		CMS Request to Re-Review Fam	November 2011	090	27.28	NA	12.36	6.28	247	FALSE			FALSE						TRUE	Remove from screen		
32480	Removal of lung, othe	RAW Review	January 2013	34			ACCP, ATS	No reliable way to determine		CMS Request to Re-Review Fam	November 2011	090	25.82	NA	11.53	5.93	4,630	FALSE			FALSE						TRUE	Remove from Screen		
32482	Removal of lung, othe	RAW Review	January 2013	34			ACCP, ATS	No reliable way to determine		CMS Request to Re-Review Fam	November 2011	090	27.44	NA	12.58	6.33	294	FALSE			FALSE						TRUE	Remove from Screen		
32491	Removal of lung, othe	RAW Review	January 2012	30			ACCP, ATS	Request further information '		CMS Request to Re-Review Fam	November 2011	090	25.24	NA	12.02	5.79	15	FALSE			FALSE						TRUE	Remove from Screen		
32551	Tube thoracostomy, ir	Chest Tube Thoracosto	April 2012	10			ACCP, ATS	3.50		Harvard Valued - Utilization ove	April 2011	000	3.04	NA	1.01	0.52	33,044	FALSE			TRUE	In September 2011, the spe	February 2012	09	Complete		TRUE	Increase		
32554	Thoracentesis, needle	Chest Tube Interventio	October 2012	04			ACCP, ACR	1.82		Harvard Valued - Utilization ove	October 2012	000	1.82	5.07	0.60	0.19	13,649	FALSE			FALSE	4 new thoracentesis codes	February 2012	10	Complete		TRUE	Decrease		
32555	Thoracentesis, needle	Chest Tube Interventio	October 2012	04			ACCP, ACR	2.27		Harvard Valued - Utilization ove	October 2012	000	2.27	7.14	0.75	0.20	229,865	FALSE			FALSE	4 new thoracentesis codes	February 2012	10	Complete		TRUE	Decrease		
32556	Pleural drainage, perc	Chest Tube Interventio	October 2012	04			ACCP, ACR	2.50		Harvard Valued - Utilization ove	October 2012	000	2.50	19.31	0.80	0.30	3,833	FALSE			FALSE	4 new thoracentesis codes	February 2012	10	Complete		TRUE	Decrease		
32557	Pleural drainage, perc	Chest Tube Interventio	October 2012	04			ACCP, ACR	3.62		Harvard Valued - Utilization ove	October 2012	000	3.12	16.44	0.98	0.26	38,244	FALSE			FALSE	4 new thoracentesis codes	February 2012	10	Complete		TRUE	Decrease		
32663	Thoracoscopy, surgica	RAW review	January 2013	34			STS	No reliable way to determine		CMS Fastest Growing	October 2008	090	24.64	NA	10.61	5.67	9,229	FALSE			FALSE						TRUE	Remove from Screen		
33010	Pericardiocentesis; ini	Pericardiocentesis and	January 2019	04				Deleted from CPT		Negative IWPUT	September 2018						6,698	FALSE			FALSE		September 2018	14	Complete		TRUE	Deleted from CPT		
33011	Pericardiocentesis; su	Pericardiocentesis and	January 2019	04				Deleted from CPT		Negative IWPUT	September 2018						87	FALSE			FALSE		September 2018	14	Complete		TRUE	Deleted from CPT		
33015	Tube pericardiostomy	Pericardiocentesis and	January 2019	04			ACC	Deleted from CPT		Negative IWPUT	April 2017						1,147	FALSE			TRUE	A RUC member requested '	September 2018	14	Complete		TRUE	Deleted from CPT		
33016	Pericardiocentesis, inc	Pericardiocentesis and	January 2019	04				5.00		Negative IWPUT	September 2018	000	4.40	NA	1.55	0.94		FALSE			FALSE		September 2018	14	Complete		TRUE	Increase		
33017	Pericardial drainage w	Pericardiocentesis and	January 2019	04				5.50		Negative IWPUT	September 2018	000	4.62	NA	1.60	0.92		FALSE			FALSE		September 2018	14	Complete		TRUE	Increase		
33018	Pericardial drainage w	Pericardiocentesis and	January 2019	04				6.00		Negative IWPUT	September 2018	000	5.40	NA	1.72	0.99		FALSE			FALSE		September 2018	14	Complete		TRUE	Increase		
33019	Pericardial drainage w	Pericardiocentesis and	January 2019	04				5.00		Negative IWPUT	September 2018	000	4.29	NA	1.49	0.82		FALSE			FALSE		September 2018	14	Complete		TRUE	Increase		
33020	Pericardiotomy for rel	Pericardiotomy	April 2018	10			AATS, STS	14.31		Negative IWPUT	April 2018	090	14.31	NA	6.59	3.29	122	FALSE			TRUE	In April 2018, the specialty	May 2018	EC	Yes		TRUE	Decrease		
33025	Creation of pericardia	Pericardiotomy	April 2018	10			AATS, STS	13.20		Negative IWPUT	April 2017	090	13.20	NA	6.29	3.02	4,535	FALSE			TRUE	In April 2018, the specialty	May 2018	EC	Yes		TRUE	Decrease		
33207	Insertion of new or re	Pacemaker or Pacing Ca	April 2011	10			ACC	8.05		Codes Reported Together 75% c	February 2010	090	7.80	NA	4.56	1.74	11,733	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Maintain		
33208	Insertion of new or re	Pacemaker or Pacing Ca	April 2011	10			ACC	8.77		Codes Reported Together 75% c	February 2010	090	8.52	NA	4.88	1.91	103,628	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Maintain		
33212	Insertion of pacemake	Pacemaker or Pacing Ca	September 2011	04			ACC	5.26		Codes Reported Together 75% c	February 2010	090	5.01	NA	3.37	1.12	317	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Decrease		
33213	Insertion of pacemake	Pacemaker or Pacing Ca	September 2011	04			ACC	5.53		CMS Fastest Growing / Codes R	October 2008	090	5.28	NA	3.43	1.18	1,113	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Decrease		
33221	Insertion of pacemake	Pacemaker or Pacing Ca	September 2011	04			ACC	5.80		Codes Reported Together 75% c	April 2011	090	5.55	NA	3.87	1.24	268	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33227	Removal of permanen	Pacemaker or Pacing Ca	September 2011	04			ACC	5.50		Codes Reported Together 75% c	April 2011	090	5.25	NA	3.56	1.17	3,452	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33228	Removal of permanen	Pacemaker or Pacing Ca	September 2011	04			ACC	5.77		Codes Reported Together 75% c	April 2011	090	5.52	NA	3.68	1.25	24,395	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33229	Removal of permanen	Pacemaker or Pacing Ca	September 2011	04			ACC	6.04		Codes Reported Together 75% c	April 2011	090	5.79	NA	3.96	1.30	5,526	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33230	Insertion of implantat	Pacemaker or Pacing Ca	September 2011	04			ACC	6.32		Codes Reported Together 75% c	April 2011	090	6.07	NA	3.86	1.37	140	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33231	Insertion of implantat	Pacemaker or Pacing Ca	September 2011	04			ACC	6.59		Codes Reported Together 75% c	April 2011	090	6.34	NA	4.04	1.43	121	FALSE			FALSE		February 2011	13			TRUE	Decrease		
33233	Removal of permanen	Pacemaker or Pacing Ca	April 2011	10			ACC	3.39		Codes Reported Together 75% c	February 2010	090	3.14	NA	3.01	0.71	8,743	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Maintain		
33240	Insertion of implantat	Pacemaker or Pacing Ca	September 2011	04			ACC	6.06		Codes Reported Together 75% c	February 2010	090	5.80	NA	3.64	1.31	217	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete		TRUE	Decrease		

33241	Removal of implantab	Pacemaker or Pacing Ca	April 2011	10		ACC	3.29	Codes Reported Together 75% c	February 2010	090	3.04	NA	2.61	0.69	6,043	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete	TRUE	Maintain
33249	Insertion or replacem	Pacemaker or Pacing Ca	April 2011	10		ACC	15.17	Codes Reported Together 75% c	February 2010	090	14.92	NA	8.73	3.34	42,661	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete	TRUE	Maintain
33262	Removal of implantab	Pacemaker or Pacing Ca	September 2011	04		ACC	6.06	Codes Reported Together 75% c	April 2011	090	5.81	NA	3.90	1.30	3,000	FALSE			FALSE		February 2011	13		TRUE	Decrease
33263	Removal of implantab	Pacemaker or Pacing Ca	September 2011	04		ACC	6.33	Codes Reported Together 75% c	April 2011	090	6.08	NA	4.01	1.36	7,980	FALSE			FALSE		February 2011	13		TRUE	Decrease
33264	Removal of implantab	Pacemaker or Pacing Ca	September 2011	04		ACC	6.60	Codes Reported Together 75% c	April 2011	090	6.35	NA	4.17	1.44	11,831	FALSE			FALSE		February 2011	13		TRUE	Decrease
33282	Implantation of patier	Implantation and Remo	April 2013	20			3.50	CMS Request - Final Rule for 20	October 2012							FALSE			FALSE		February 2017	12	yes	TRUE	Decrease
33284	Removal of an implan	Implantation and Remo	April 2013	20			3.00	CMS Request - Final Rule for 20	October 2012							FALSE			FALSE		February 2017	12	yes	TRUE	Decrease
33405	Replacement, aortic v	Valve Replacement and	April 2012	40		STS	41.32	CMS High Expenditure Procedur	September 2011	090	41.32	NA	15.58	9.42	17,344	FALSE			FALSE					TRUE	Maintain
33430	Replacement, mitral v	Valve Replacement and	April 2012	40		STS	50.93	High IWPUT / CMS High Expend	February 2008	090	50.93	NA	19.29	11.59	7,658	FALSE			FALSE					TRUE	Maintain
33533	Coronary artery bypas	Valve Replacement and	April 2012	40		STS	34.98	CMS High Expenditure Procedur	September 2011	090	33.75	NA	13.23	7.71	60,180	FALSE			FALSE					TRUE	Increase
33620	Application of right ar	New Technology Revie	January 2019	37		STS	CPT Article published July 20	New Technology/New Services ,	January 2015	090	30.00	NA	11.30	6.87	56	TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33621	Transthoracic insertio	New Technology Revie	January 2019	37		STS	CPT Article published July 20	New Technology/New Services ,	January 2015	090	16.18	NA	7.30	3.73		TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33622	Reconstruction of con	New Technology Revie	January 2019	37		STS	CPT Article published July 20	New Technology/New Services ,	January 2015	090	64.00	NA	21.49	14.69	1	TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33741	Transcatheter atrial se	Atrial Septostomy	January 2020	13			14.00	CMS Request - Final Rule for 20	September 2019	000	14.00	NA	4.98	3.12		FALSE			FALSE		September 2019	16	yes	TRUE	Maintain
33745	Transcatheter intraca	Atrial Septostomy	January 2020	13			20.00	CMS Request - Final Rule for 20	September 2019	000	20.00	NA	7.24	3.96		FALSE			FALSE		September 2019	16	yes	TRUE	Maintain
33746	Transcatheter intraca	Atrial Septostomy	January 2020	13			10.50	CMS Request - Final Rule for 20	September 2019	ZZZ	8.00	NA	2.88	1.45		FALSE			FALSE		September 2019	16	yes	TRUE	Maintain
33863	Ascending aorta graft,	Aortic Graft	February 2008	S		STS, AATS	Remove from screen	High IWPUT	February 2008	090	58.79	NA	19.72	13.40	1,812	FALSE			FALSE					TRUE	Remove from Screen
33945	Heart transplant, with	ECMO-ECLS	April 2014	11		STS, AAP, /	16.00	CMS Request - Final Rule for 20	November 2014	090	89.50	NA	31.88	20.34	667	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33946	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	6.00	CMS Request - Final Rule for 20	November 2014	XXX	6.00	NA	1.82	1.21	603	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33947	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	6.63	CMS Request - Final Rule for 20	November 2013	XXX	6.63	NA	2.00	1.41	1,395	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33948	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.73	CMS Request - Final Rule for 20	November 2013	XXX	4.73	NA	1.49	0.75	4,436	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33949	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.60	CMS Request - Final Rule for 20	November 2013	XXX	4.60	NA	1.41	0.74	5,342	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33951	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	8.15	CMS Request - Final Rule for 20	November 2013	000	8.15	NA	2.36	1.84	1	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33952	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	8.43	CMS Request - Final Rule for 20	November 2013	000	8.15	NA	2.56	1.76	1,439	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33953	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	9.83	CMS Request - Final Rule for 20	November 2013	000	9.11	NA	2.63	2.07		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33954	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	9.43	CMS Request - Final Rule for 20	November 2014	000	9.11	NA	2.74	2.04	354	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33956	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	16.00	CMS Request - Final Rule for 20	November 2014	000	16.00	NA	4.73	3.63	352	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33957	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.00	CMS Request - Final Rule for 20	November 2014	000	3.51	NA	1.08	0.78		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33958	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.05	CMS Request - Final Rule for 20	November 2014	000	3.51	NA	1.08	0.78	72	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33959	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.69	CMS Request - Final Rule for 20	November 2014	000	4.47	NA	1.35	1.02		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33960	Prolonged extracorpo	ECMO-ECLS	April 2014	11		STS, AAP, /	Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE			TRUE	October 2013 the RUC recc	February 2014	23	Complete	TRUE	Deleted from CPT
33961	Prolonged extracorpo	ECMO-ECLS	April 2014	11		STS, AAP, /	Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE			TRUE	October 2013 the RUC recc	February 2014	23	Complete	TRUE	Deleted from CPT
33962	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.73	CMS Request - Final Rule for 20	November 2014	000	4.47	NA	1.35	1.02	20	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33963	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	9.00	CMS Request - Final Rule for 20	November 2014	000	9.00	NA	2.60	2.04		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33964	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	9.50	CMS Request - Final Rule for 20	November 2014	000	9.50	NA	2.74	2.14	22	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33965	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	3.51	CMS Request - Final Rule for 20	November 2014	000	3.51	NA	1.08	0.78		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33966	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	4.50	CMS Request - Final Rule for 20	November 2014	000	4.50	NA	1.44	0.97	383	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33969	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	6.00	CMS Request - Final Rule for 20	November 2014	000	5.22	NA	1.56	1.18		FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33984	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	6.38	CMS Request - Final Rule for 20	November 2014	000	5.46	NA	1.58	1.25	543	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33985	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	9.89	CMS Request - Final Rule for 20	November 2014	000	9.89	NA	2.85	2.24	1	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33986	Extracorporeal membi	ECMO-ECLS	April 2014	11		STS, AAP, /	10.00	CMS Request - Final Rule for 20	November 2014	000	10.00	NA	2.99	2.28	221	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33987	Arterial exposure with	ECMO-ECLS	April 2014	11		STS, AAP, /	4.08	CMS Request - Final Rule for 20	November 2014	ZZZ	4.04	NA	1.13	0.93	41	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33988	Insertion of left heart	ECMO-ECLS	April 2014	11		STS, AAP, /	15.00	CMS Request - Final Rule for 20	November 2014	000	15.00	NA	4.28	3.41	40	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
33989	Removal of left heart	ECMO-ECLS	April 2014	11		STS, AAP, /	9.50	CMS Request - Final Rule for 20	November 2013	000	9.50	NA	2.74	2.14	14	FALSE			FALSE		February 2014	23	Complete	TRUE	Maintain
34701	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	23.71	Codes Reported Together 75%o	January 2017	090	23.71	NA	6.98	5.46	824	FALSE			FALSE					TRUE	Decrease
34702	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	36.00	Codes Reported Together 75%o	January 2017	090	36.00	NA	9.51	8.40	99	FALSE			FALSE					TRUE	Decrease
34703	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	26.52	Codes Reported Together 75%o	January 2017	090	26.52	NA	7.34	6.16	1,118	FALSE			FALSE					TRUE	Decrease
34704	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	45.00	Codes Reported Together 75%o	January 2017	090	45.00	NA	11.18	10.63	141	FALSE			FALSE					TRUE	Decrease
34705	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	29.58	Codes Reported Together 75%o	January 2017	090	29.58	NA	8.07	6.86	13,089	FALSE			FALSE					TRUE	Decrease
34706	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	45.00	Codes Reported Together 75%o	January 2017	090	45.00	NA	11.45	10.52	641	FALSE			FALSE					TRUE	Decrease
34707	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	22.28	Codes Reported Together 75%o	January 2017	090	22.28	NA	6.55	5.13	652	FALSE			FALSE					TRUE	Decrease
34708	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	36.50	Codes Reported Together 75%o	January 2017	090	36.50	NA	8.89	8.52	85	FALSE			FALSE					TRUE	Decrease
34709	Placement of extensic	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	6.50	Codes Reported Together 75%o	January 2017	ZZZ	6.50	NA	1.40	1.51	3,632	FALSE			FALSE					TRUE	Decrease
34710	Delayed placement of	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	15.00	Codes Reported Together 75%o	January 2017	090	15.00	NA	4.80	3.43	1,186	FALSE			FALSE					TRUE	Decrease
34711	Delayed placement of	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	6.00	Codes Reported Together 75%o	January 2017	ZZZ	6.00	NA	1.26	1.42	367	FALSE			FALSE					TRUE	Decrease
34712	Transcatheter deliver	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	12.00	Codes Reported Together 75%o	January 2017	090	12.00	NA	4.47	2.71	1,214	FALSE			FALSE					TRUE	Decrease
34713	Percutaneous access a	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	2.50	Codes Reported Together 75%o	January 2017	ZZZ	2.50	NA	0.53	0.59	16,159	FALSE			FALSE					TRUE	Decrease
34714	Open femoral artery e	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	5.25	Codes Reported Together 75%o	January 2017	ZZZ	5.25	NA	1.40	1.21	487	FALSE			FALSE					TRUE	Decrease
34715	Open axillary/subclavi	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	6.00	Codes Reported Together 75%o	January 2017	ZZZ	6.00	NA	1.32	1.43	206	FALSE			FALSE					TRUE	Decrease
34716	Open axillary/subclavi	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	7.19	Codes Reported Together 75%o	January 2017	ZZZ	7.19	NA	2.00	1.63	798	FALSE			FALSE					TRUE	Decrease
34800	Endovascular repair o	Endovascular Repair Pr	January 2017	10		AAOHNS	Deleted from CPT	Codes Reported Together 75%o	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34802	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Pre-Time Analysis / Codes Repo	January 2014							FALSE			TRUE	Referred to CPT for revisio	September 2016		yes	TRUE	Deleted from CPT
34803	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34804	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34805	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
34806	Transcatheter placem	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
34812	Open femoral artery e	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	4.13	Pre-Time Analysis	January 2014	ZZZ	4.13	NA	0.90	0.98	9,013	FALSE			TRUE	Referred to CPT for revisio	September 2016	27	yes	TRUE	Decrease
34820	Open iliac artery expo	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	7.00	Codes Reported Together 75%o	January 2017	ZZZ	7.00	NA	1.44	1.67	82	FALSE			FALSE					TRUE	Decrease
34825	Placement of proxima	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Pre-Time Analysis / Codes Repo	January 2014							FALSE			TRUE	Referred to CPT for revisio	September 2016	27	yes	TRUE	Deleted from CPT
34826	Placement of proxima	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
34833	Open iliac artery expo	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	8.16	Codes Reported Together 75%o	January 2017	ZZZ	8.16	NA	1.29	1.96	46	FALSE			FALSE					TRUE	Decrease
34834	Open brachial artery e	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	2.65	Codes Reported Together 75%o	January 2017	ZZZ	2.65	NA	0.48	0.64	366	FALSE			FALSE					TRUE	Decrease
34900	Endovascular repair o	Endovascular Repair Pr	January 2017	10		SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
35301	Thromboendarterectc	Thromboendarterecton	January 2013	21		SVS	21.16	CMS High Expenditure Procedur	September 2011	090	21.16	NA	6.69	5.13	35,904	FALSE			FALSE					TRUE	Increase
35450	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35452	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35454	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	February 2010							FALSE			FALSE		February 2010	07		TRUE	Deleted from CPT
35456	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	February 2010							FALSE			FALSE		February 2010	07		TRUE	Deleted from CPT
35458	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35459	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	February 2010							FALSE			FALSE		February 2010	07		TRUE	Deleted from CPT
35460	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35470	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	October 2008							FALSE			TRUE	The code is part of a comp	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35471	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	CMS Fastest Growing / Codes R	October 2009							FALSE			TRUE	In January 2015, the Joint C	October 2015		Deleted fr	TRUE	Deleted from CPT
35472	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	CMS Fastest Growing / Codes R	October 2009							FALSE			TRUE	The code is part of a comp	Removed from CPT referra	Complete		TRUE	Deleted from CPT
35473	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	February 2010							FALSE			TRUE	The code is part of a comp	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35474	Deleted from CPT	Endovascular Revascula	April 2010	07		ACC, ACR,	Deleted from CPT	CMS Fastest Growing	October 2008							FALSE			TRUE	The code is part of a comp	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35475	Transluminal balloon a	Open and Percutaneou	January 2016	15		ACR, SIR, S	Deleted from CPT	CMS Fastest Growing / CMS Hig	September 2011							FALSE			TRUE	In January 2015, the Joint C	October 2015		Deleted fr	TRUE	Deleted from CPT
35476	Transluminal balloon a	Open and Percutaneou	January 2016	15	RUC	ACR, SIR, S	Deleted from CPT	CMS Fastest Growing / CMS Hig	September 2011							FALSE			TRUE	In January 2015, the Joint C	October 2015		Deleted fr	TRUE	Deleted from CPT
35490	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35491	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35492	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35493	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	February 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35494	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35495	Deleted from CPT	Endovascular Revascula	April 2010	07		SIR, ACR, S	Deleted from CPT	High Volume Growth1	February 2008							FALSE			TRUE	The RUC recommended tha	February 2010	07	Deleted- N	TRUE	Deleted from CPT
35701	Exploration not follow	Exploration of Artery	January 2019	06		ACS, SVS	7.50	Negative IWPUT	January 2018	090	7.50	NA	4.08	1.25	823	FALSE			TRUE	The RUC identified CPT coc	September 2018	17	Complete	TRUE	Decrease
35702	Exploration not follow	Exploration of Artery	January 2019	06			7.12	Negative IWPUT	September 2018	090	7.12	NA	3.38	1.55		FALSE			FALSE		September 2018	17	Complete	TRUE	Decrease
35703	Exploration not follow	Exploration of Artery	January 2019	06			7.50	Negative IWPUT	September 2018	090	7.50	NA	3.00	1.74		FALSE			FALSE		September 2018	17	Complete	TRUE	Decrease

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37232	Revascularization, enc	Endovascular Revascula	January 2019	37	January 2022	RUC	SVS, ACS, S	Refer to CPT. 4.00	High Volume Growth1	February 2010	ZZZ	4.00	23.55	1.01	0.79	14,835	FALSE		TRUE	In October 2018, 37225, 37	September 2021			FALSE	Decrease
37233	Revascularization, enc	Endovascular Revascula	January 2019	37	January 2022	RUC	SVS, ACS, S	Refer to CPT. 6.50	High Volume Growth1	February 2010	ZZZ	6.50	27.13	1.62	1.34	9,241	FALSE		TRUE	In October 2018, 37225, 37	September 2021			FALSE	Decrease
37234	Revascularization, enc	Endovascular Revascula	January 2019	37	January 2022	RUC	SVS, ACS, S	Refer to CPT. 5.50	High Volume Growth1	February 2010	ZZZ	5.50	111.73	1.62	1.18	343	FALSE		TRUE	In October 2018, 37225, 37	September 2021			FALSE	Decrease
37235	Revascularization, enc	Endovascular Revascula	January 2019	37	January 2022	RUC	SVS, ACS, S	Refer to CPT. 7.80	High Volume Growth1	February 2010	ZZZ	7.80	116.61	2.24	1.42	100	FALSE		TRUE	In October 2018, 37225, 37	September 2021			FALSE	Decrease
37236	Transcatheter placem	Transcatheter Placemei	April 2013	09			SVS, ACS, S	9.00	Codes Reported Together 75% c	February 2013	000	8.75	84.52	2.32	1.81	13,074	FALSE		FALSE		February 2013	10	Complete	TRUE	Decrease
37237	Transcatheter placem	Transcatheter Placemei	April 2013	09			SVS, ACS, S	4.25	Codes Reported Together 75% c	February 2013	ZZZ	4.25	43.32	0.98	0.90	1,497	FALSE		FALSE		February 2013	10	Complete	TRUE	Decrease
37238	Transcatheter placem	Transcatheter Placemei	April 2013	09			SVS, ACS, S	6.29	Codes Reported Together 75% c	February 2013	000	6.04	106.77	1.72	1.17	10,579	FALSE		FALSE		February 2013	10	Complete	TRUE	Decrease
37239	Transcatheter placem	Transcatheter Placemei	April 2013	09			SVS, ACS, S	3.34	Codes Reported Together 75% c	February 2013	ZZZ	2.97	53.45	0.83	0.62	4,688	FALSE		FALSE		February 2013	10	Complete	TRUE	Decrease
37241	Vascular embolization	Embolization and Occlu	April 2013	08			SVS, ACS, S	9.00	Codes Reported Together 75% c	February 2010	000	8.75	137.81	2.50	1.30	1,922	FALSE		FALSE		February 2013	09		TRUE	Decrease
37242	Vascular embolization	Embolization and Occlu	April 2013	08			SVS, ACS, S	11.98	Codes Reported Together 75% c	February 2010	000	9.80	220.06	2.58	1.41	8,635	FALSE		FALSE		February 2013	09		TRUE	Decrease
37243	Vascular embolization	Embolization and Occlu	April 2013	08			SVS, ACS, S	14.00	Codes Reported Together 75% c	February 2010	000	11.74	271.90	3.36	1.04	14,067	FALSE		FALSE		February 2013	09		TRUE	Decrease
37244	Vascular embolization	Embolization and Occlu	April 2013	08			SVS, ACS, S	14.00	Codes Reported Together 75% c	February 2010	000	13.75	198.34	4.14	1.26	12,731	FALSE		FALSE		February 2013	09		TRUE	Decrease
37246	Transluminal balloon a	Open and Percutaneou	January 2016	15		RUC	ACR, SIR, S	7.00	Codes Reported Together 75% c	October 2015	000	7.00	51.34	1.87	1.21	8,680	FALSE		FALSE		October 2015	24	Complete	TRUE	Decrease
37247	Transluminal balloon a	Open and Percutaneou	January 2016	15		RUC	ACR, SIR, S	3.50	Codes Reported Together 75% c	October 2015	ZZZ	3.50	14.34	0.73	0.70	760	FALSE		FALSE		October 2015	24	Complete	TRUE	Decrease
37248	Transluminal balloon a	Open and Percutaneou	January 2016	15		RUC	ACR, SIR, S	6.00	Codes Reported Together 75% c	October 2015	000	6.00	37.31	1.79	0.82	15,577	FALSE		FALSE		October 2015	24	Complete	TRUE	Decrease
37249	Transluminal balloon a	Open and Percutaneou	January 2016	15		RUC	ACR, SIR, S	2.97	Codes Reported Together 75% c	October 2015	ZZZ	2.97	11.33	0.76	0.48	3,865	FALSE		FALSE		October 2015	24	Complete	TRUE	Decrease
37250	Intravascular ultrasou	Intravascular Ultrasoun	January 2015	07			ACC, SCAI,	Deleted from CPT	Final Rule for 2015	July 2014							FALSE		TRUE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Deleted from CPT
37251	Intravascular ultrasou	Intravascular Ultrasoun	January 2015	07			ACC,SCAI,	Deleted from CPT	Final Rule for 2015	July 2014							FALSE		TRUE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Deleted from CPT
37252	Intravascular ultrasou	Intravascular Ultrasoun	October 2018	14			ACC,SCAI,	1.80	Final Rule for 2015 / Work Neut	July 2014	ZZZ	1.80	30.84	0.45	0.36	60,377	FALSE		FALSE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Decrease
37253	Intravascular ultrasou	Intravascular Ultrasoun	October 2018	14			ACC,SCAI,	1.44	Final Rule for 2015 / Work Neut	July 2014	ZZZ	1.44	3.65	0.36	0.27	91,408	FALSE		FALSE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Decrease
37609	Ligation or biopsy, ter	Ligation	September 2007	16			SVS, ACS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	010	3.05	5.75	2.33	0.63	14,539	FALSE		FALSE					TRUE	PE Only
37619	Ligation of inferior ve	Ligation of Inferior Ven	April 2011	13			ACS, SVS	37.60	Codes Reported Together 75% c	February 2011	090	30.00	NA	13.67	7.33	33	FALSE		FALSE		February 2011	15		TRUE	Increase
37620	Interruption, partial o	Major Vein Revision	April 2010	45			ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup accepts th	February 2011	15	Code Dele	TRUE	Deleted from CPT
37760	Ligation of perforator	Perorator Vein Ligation	April 2009	10			SVS, ACS	10.69	Site of Service Anomaly	September 2007	090	10.78	NA	5.01	2.53	65	FALSE		TRUE	The RUC referred the servi	February 2009	19	Complete	TRUE	Maintain
37761	Ligation of perforator	Perforator Vein Ligatior	April 2009	10			SVS, ACS	9.00	Site of Service Anomaly	April 2009	090	9.13	NA	4.43	2.12	350	FALSE		FALSE					TRUE	Increase
37765	Stab phlebectomy of v	Stab Phlebectomy of Va	April 2018	12			ACS, SIR, S	4.80	High Volume Growth1 / CMS Fa	February 2008	010	4.80	7.22	2.08	1.03	14,709	FALSE		FALSE					TRUE	Decrease
37766	Stab phlebectomy of v	Stab Phlebectomy of Va	April 2018	12			ACS, SIR, S	6.00	High Volume Growth1 / CMS Fa	February 2008	010	6.00	7.92	2.42	1.25	11,253	FALSE		FALSE					TRUE	Decrease
37785	Ligation, division, and,	Ligation	September 2007	16			APMA, SVS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	3.93	5.80	2.69	0.91	934	FALSE		FALSE					TRUE	PE Only
38220	Diagnostic bone marr	Diagnostic Bone Marro	April 2016	06			ASCO, ASH	1.20	CMS High Expenditure Procedur	February 2016	XXX	1.20	3.57	0.66	0.17	7,044	FALSE		FALSE		February 2016	16	Complete	TRUE	Decrease
38221	Diagnostic bone marr	Diagnostic Bone Marro	April 2016	06			ASCO, ASH	1.28	CMS High Expenditure Procedur	July 2015	XXX	1.28	3.37	0.66	0.09	12,465	FALSE		TRUE	Prior to the January 2016 R	February 2016	16	Complete	TRUE	Decrease
38222	Diagnostic bone marr	Diagnostic Bone Marro	April 2016	06			ASCO, ASH	1.44	CMS High Expenditure Procedur	February 2016	XXX	1.44	3.65	0.69	0.11	120,998	FALSE		FALSE		February 2016	16	Complete	TRUE	Decrease
38505	Biopsy or excision of l	Needle Biopsy of Lympl	October 2020	15			ACR, SIR	1.59	Harvard Valued - Utilization ove	October 2019	000	1.14	2.36	0.77	0.11	33,584	FALSE		FALSE					TRUE	Increase
38542	Dissection, deep jugul	Jugular Node Dissectior	April 2008	40			ACS, AAO-	7.85	Site of Service Anomaly	September 2007	090	7.95	NA	5.90	1.30	571	FALSE		FALSE					TRUE	Increase
38570	Laparoscopy, surgical;	Laparoscopy Lymphade	September 2014	12			AUA	9.34	010-Day Global Post-Operative '	January 2014	010	8.49	NA	5.18	1.44	5,714	FALSE		FALSE					TRUE	Maintain
38571	Laparoscopy, surgical;	Laparoscopy Lymphade	September 2014	12			AUA	12.00	CMS Fastest Growing / 010-Day	October 2008	010	12.00	NA	5.87	1.49	17,981	FALSE		FALSE					TRUE	Decrease
38572	Laparoscopy, surgical;	Laparoscopy Lymphade	September 2014	12			ACOG	15.60	010-Day Global Post-Operative '	January 2014	010	15.60	NA	8.67	2.38	2,251	FALSE		FALSE					TRUE	Decrease
38792	Injection procedure; r	Radioactive Tracer	January 2018	23				0.65	Negative IWPUT	April 2017	000	0.65	1.72	0.23	0.09	33,143	FALSE		FALSE					TRUE	Increase
39400	Mediastinoscopy, incl	Mediastinoscopy with E	January 2015	08			STS	Deleted from CPT	Pre-Time Analysis	January 2014							FALSE		TRUE	Referred to CPT for revisio	October 2014	14	Complete	TRUE	Deleted from CPT
39401	Mediastinoscopy; incl	Mediastinoscopy with E	January 2015	08			STS	5.44	Pre-Time Analysis	October 2014	000	5.44	NA	2.30	1.25	535	FALSE		FALSE	Referred to CPT for revisio	October 2014	14	Complete	TRUE	Decrease
39402	Mediastinoscopy; with	Mediastinoscopy with E	January 2015	08			STS	7.50	Pre-Time Analysis	October 2014	000	7.25	NA	2.87	1.65	4,086	FALSE		FALSE	Referred to CPT for revisio	October 2014	14	Complete	TRUE	Increase
40490	Biopsy of lip	Biopsy of Lip	September 2011	21			AAO-HNS,	1.22	Harvard Valued - Utilization ove	April 2011	000	1.22	2.34	0.68	0.13	32,762	FALSE		FALSE					TRUE	Maintain
40650	Repair lip, full thickne	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical staff pre-time revi	Emergent Procedures	October 2015	090	3.78	9.72	4.60	0.71	355	TRUE	Nov 2016 yes	FALSE					TRUE	PE Only
40800	Drainage of abscess, c	RAW	April 2014	52				Maintain	010-Day Global Post-Operative '	January 2014	010	1.23	4.87	2.19	0.13	2,390	FALSE		FALSE					TRUE	Maintain
40801	Drainage of abscess, c	Ostectomy	January 2020	37			APMA, AA	Maintain. Reduced 99238 to	Site of Service Anomaly (99238-	September 2007	010	2.63	5.88	2.97	0.25	1,609	FALSE		FALSE					TRUE	PE Only
40808	Biopsy, vestibule of m	Biopsy of Mouth Lesion	April 2018	13			AAOHNS, /	1.05	Negative IWPUT	April 2017	010	1.05	3.81	1.36	0.13	10,517	FALSE		FALSE					TRUE	Increase
40812	Excision of lesion of m	RAW	April 2014	52				Maintain	010-Day Global Post-Operative '	January 2014	010	2.37	5.96	2.85	0.25	5,703	FALSE		FALSE					TRUE	Maintain
40820	Destruction of lesion c	RAW	April 2014	52				Maintain	010-Day Global Post-Operative '	January 2014	010	1.34	6.47	3.54	0.14	1,264	FALSE		FALSE					TRUE	Maintain
41530	Submucosal ablation c	Submucosal ablation of	April 2015	26		RUC	AAO-HNS	3.50	Final Rule for 2015	July 2014	000	3.50	25.25	7.42	0.47	350	FALSE		FALSE					TRUE	Decrease
42145	Palatopharyngoplasty	Palatopharyngoplasty	April 2008	41			AAO-HNS	9.63	Site of Service Anomaly	September 2007	090	9.78	NA	9.13	1.34	518	FALSE		FALSE					TRUE	Maintain
42415	Excision of parotid tur	Excise Parotid Gland/Le	February 2011	27			ACS, AAO-	18.12	Site of Service Anomaly	September 2007	090	17.16	NA	11.16	2.42	5,439	FALSE		FALSE					TRUE	Maintain
42420	Excision of parotid tur	Excise Parotid Gland/Le	February 2011	27			ACS, AAO-	21.00	Site of Service Anomaly	September 2007	090	19.53	NA	12.21	2.75	1,561	FALSE		FALSE					TRUE	Maintain
42440	Excision of submandit	Submandibular Gland E	October 2010	64			AAO-HNS,	7.13	Site of Service Anomaly	September 2007	090	6.14	NA	5.06	0.86	1,780	FALSE		FALSE					TRUE	Maintain
43191	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	2.78	MPC List	September 2011	000	2.49	NA	1.65	0.36	2,988	FALSE		FALSE					TRUE	Increase
43192	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	3.21	MPC List	September 2011	000	2.79	NA	1.73	0.41	211	FALSE		FALSE					TRUE	Increase
43193	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	3.36	MPC List	September 2011	000	2.79	NA	1.72	0.39	210	FALSE		FALSE					TRUE	Increase
43194	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	3.99	MPC List	September 2011	000	3.51	NA	1.55	0.53	115	FALSE		FALSE					TRUE	Increase
43195	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	3.21	MPC List	September 2011	000	3.07	NA	1.83	0.43	569	FALSE		FALSE					TRUE	Increase
43196	Esophagoscopy, rigid,	Esophagoscopy	October 2012	10			AAO-HNS,	3.36	MPC List	September 2011	000	3.31	NA	1.94	0.43	486	FALSE		FALSE					TRUE	Increase
43197	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	1.59	MPC List	September 2011	000	1.52	4.07	0.65	0.23	1,136	FALSE		FALSE					TRUE	Maintain
43198	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	1.89	MPC List	September 2011	000	1.82	4.32	0.79	0.25	255	FALSE		FALSE					TRUE	Maintain
43200	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	1.59	MPC List	September 2011	000	1.42	6.21	0.92	0.21	5,390	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43201	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	1.90	MPC List	September 2011	000	1.72	5.78	1.04	0.23	220	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Decrease
43202	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	1.89	MPC List	September 2011	000	1.72	8.94	1.05	0.22	2,578	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43204	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	2.89	MPC List	September 2011	000	2.33	NA	1.35	0.25	13	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Decrease
43205	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	3.00	MPC List	September 2011	000	2.44	NA	1.40	0.26	159	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Decrease
43206	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	2.39	MPC List	September 2011	000	2.29	6.52	1.33	0.25	21	FALSE		FALSE					TRUE	Decrease
43211	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	4.58	MPC List	September 2011	000	4.20	NA	2.17	0.45	99	FALSE		FALSE					TRUE	Decrease
43212	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	3.73	MPC List	September 2011	000	3.40	NA	1.57	0.56	585	FALSE		FALSE					TRUE	Decrease
43213	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	5.00	MPC List	September 2011	000	4.63	33.35	2.24	0.68	187	FALSE		FALSE					TRUE	Decrease
43214	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	3.78	MPC List	September 2011	000	3.40	NA	1.78	0.43	215	FALSE		FALSE					TRUE	Decrease
43215	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	2.60	MPC List	September 2011	000	2.44	9.30	1.33	0.34	989	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43216	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	2.40	MPC List	September 2011	000	2.30	10.01	1.33	0.26	195	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43217	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	2.90	MPC List	September 2011	000	2.80	9.72	1.56	0.30	53	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43219	Esophagoscopy, rigid (	Esophagoscopy	October 2012	10			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Deleted from CPT
43220	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	2.10	MPC List	September 2011	000	2.00	27.96	1.18	0.26	2,069	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43226	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AAO-HNS,	2.34	MPC List	September 2011	000	2.24	8.98	1.23	0.33	1,841	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43227	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	3.26	MPC List	September 2011	000	2.89	15.89	1.58	0.33	191	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Decrease
43228	Esophagoscopy, rigid (	Esophagoscopy	October 2012	10			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Deleted from CPT
43229	Esophagoscopy, flexib	Esophagoscopy	October 2012	10			AGA, ASGE	3.72	MPC List	September 2011	000	3.49	18.25	1.83	0.42	2,331	FALSE		FALSE					TRUE	Decrease
43231	Esophagoscopy, flexib	Esophagoscopy	April 2013	10			AGA, ASGE	3.19	MPC List	September 2011	000	2.80	NA	1.55	0.28	502	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43232	Esophagoscopy, flexib	Esophagoscopy	April 2013	10			AGA, ASGE	3.83	MPC List	September 2011	000	3.59	NA	1.83	0.37	435	FALSE		FALSE	Several specific codes iden	May 2012			TRUE	Decrease
43233	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.45	MPC List	October 2012	000	4.07	NA	2.03	0.59	1,577	FALSE		FALSE		October 2012	14	Complete	TRUE	Decrease
43234	Upper gastrointestina	Esophagoscopy	April 2013	10			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE		TRUE	Several specific codes iden	February 2012	11	Complete	TRUE	Deleted from CPT
43235	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	2.26	MPC List / CMS High Expenditur	October 2010	000	2.09	6.59	1.23	0.25	323,621	FALSE		FALSE	Several specific codes iden	October 2012	14	Complete	TRUE	Decrease
43236	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	2.57	CMS Fastest Growing / MPC List	October 2008	000	2.39	9.43	1.37	0.26	16,281	TRUE	Apr 2009 ; Yes	FALSE	Several specific codes iden	October 2012	14	Complete	TRUE	Decrease
43237	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	3.85	MPC List	September 2011	000	3.47	NA	1.85	0.37	18,922	FALSE		TRUE	In the Panel Action memo '	February 2013	12	Complete	TRUE	Decrease
43238	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	4.50	MPC List	September 2011	000	4.16	NA	2.15	0.45	14,141	FALSE		TRUE	In the Panel Action memo '	February 2013	12	Complete	TRUE	Decrease
43239	Esophagogastroduode	EGD with Biopsy	April 2019	12			ACG, ACS,	2.39	MPC List / CMS Request - Final I	October 2010	000	2.39	8.84	1.37	0.26	1,424,058	FALSE		FALSE	Several specific codes identified by CMS through the MPC List sc				TRUE	Maintain
43240	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	7.25	MPC List	September 2011	000	7.15	NA	3.48	0.76	1,002	FALSE		TRUE	In the Panel Action memo '	February 2013	12	Complete	TRUE	Increase
43241	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	2.59	MPC List	September 2011	000	2.49	NA	1.36	0.28	4,312	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Maintain
43242	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	5.39	CMS Fastest Growing / MPC List	October 2008	000	4.73	NA	2.41	0.49	26,340	TRUE	Mar 2009 Yes	TRUE	In the Panel Action memo '	February 2013	12	Complete	TRUE	Decrease
43243	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.37	MPC List	September 2011	000	4.27	NA	2.14	0.48	647	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43244	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.50	MPC List	September 2011	000	4.40	NA	2.26	0.46	22,233	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43245	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	3.18	MPC List	September 2011	000	3.08	15.04	1.64	0.42	15,047	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Maintain
43246	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	4.32	MPC List	September 2011	000	3.56	NA	1.78	0.49	71,081	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Maintain
43247	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	3.27	MPC List	September 2011	000	3.11	8.12	1.67	0.37	28,637	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43248	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	3.01	MPC List	September 2011	000	2.91	9.18	1.60	0.32	110,879	FALSE		FALSE	Several specific codes iden	October 2012			TRUE	Decrease

43249	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	2.77	MPC List	September 2011	000	2.67	31.47	1.49	0.31	125,878	FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43250	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	3.07	MPC List	September 2011	000	2.97	10.44	1.58	0.43	3,775	FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43251	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	3.57	MPC List	September 2011	000	3.47	11.28	1.84	0.39	35,888	FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43253	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	5.39	MPC List	February 2012	000	4.73	NA	2.41	0.49	2,309	FALSE			TRUE	In the Panel Action memo	February 2013	12	Complete	TRUE	Decrease
43254	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	5.25	MPC List	October 2012	000	4.87	NA	2.46	0.52	5,797	FALSE			FALSE		October 2012	14	Complete	TRUE	Decrease
43255	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.20	MPC List	September 2011	000	3.56	16.12	1.88	0.39	62,091	FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43256	Upper gastrointestina	EGD	January 2013	08			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Deleted from CPT
43257	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.25	MPC List	September 2011	000	4.15	NA	2.11	0.49	148	FALSE			FALSE	Several specific codes iden	October 2012			TRUE	Decrease
43258	Upper gastrointestina	EGD	January 2013	08			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	October 2012	14	Complete	TRUE	Deleted from CPT
43259	Esophagogastroduode	EGD	April 2013	11			AGA, ASGE	4.74	CMS Fastest Growing	October 2008	000	4.04	NA	2.10	0.43	34,294	TRUE	Mar 2009	Yes	TRUE	In the Panel Action memo	February 2013	12	Complete	TRUE	Decrease
43260	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	5.95	MPC List	September 2011	000	5.85	NA	2.90	0.63	4,795	FALSE			TRUE	Several specific codes iden	February 2013	13	Complete	TRUE	Maintain
43261	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	6.25	MPC List	September 2011	000	6.15	NA	3.04	0.65	7,154	FALSE			FALSE	Several specific codes iden	January 2013	13		TRUE	Decrease
43262	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	6.60	MPC List	September 2011	000	6.50	NA	3.19	0.70	30,450	FALSE			FALSE	Several specific codes iden	January 2013	13		TRUE	Decrease
43263	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	7.28	MPC List	September 2011	000	6.50	NA	3.15	0.74	67	FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Maintain
43264	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	6.73	Harvard Valued - Utilization ove	April 2011	000	6.63	NA	3.25	0.71	56,121	FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Decrease
43265	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	8.03	MPC List	September 2011	000	7.93	NA	3.83	0.85	2,820	FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Decrease
43266	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.40	MPC List	October 2012	000	3.92	NA	1.93	0.48	5,767	FALSE			FALSE		October 2012	14	Complete	TRUE	Decrease
43267	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Deleted from CPT
43268	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	Deleted from CPT	Harvard Valued - Utilization ove	April 2011							FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Deleted from CPT
43269	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Deleted from CPT
43270	Esophagogastroduode	EGD	January 2013	08			AGA, ASGE	4.39	MPC List	October 2012	000	4.01	18.21	2.08	0.44	20,628	FALSE			FALSE		October 2012	14	Complete	TRUE	Decrease
43271	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Deleted from CPT
43272	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Deleted from CPT
43273	Endoscopic cannulatic	ERCP	April 2013	12			AGA, ASGE	2.24	MPC List	September 2011	ZZZ	2.24	NA	1.00	0.25	8,668	FALSE			FALSE	Several specific codes iden	February 2013	13		TRUE	Maintain
43274	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	8.74	MPC List	September 2011	000	8.48	NA	4.07	0.92	43,064	FALSE			FALSE		February 2013	13		TRUE	Decrease
43275	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	6.96	MPC List	September 2011	000	6.86	NA	3.35	0.74	14,287	FALSE			FALSE		February 2013	13		TRUE	Decrease
43276	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	9.10	MPC List	September 2011	000	8.84	NA	4.24	0.94	16,434	FALSE			FALSE		February 2013	13		TRUE	Decrease
43277	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	7.11	MPC List	September 2011	000	6.90	NA	3.37	0.74	6,694	FALSE			FALSE		February 2013	13		TRUE	Decrease
43278	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE	8.08	MPC List	September 2011	000	7.92	NA	3.81	0.85	600	FALSE			FALSE		February 2013	13		TRUE	Decrease
43450	Dilation of esophagus	Dilation of Esophagus	October 2012	17			AGA, ASGE	1.30	MPC List	September 2011	000	1.28	4.18	0.88	0.15	71,670	FALSE			FALSE					TRUE	Decrease
43453	Dilation of esophagus	Dilation of Esophagus	October 2012	17			AGA, ASGE	1.51	MPC List	September 2011	000	1.41	25.10	0.93	0.16	1,698	FALSE			FALSE	Several specific codes iden	May 2012			TRUE	Maintain
43456	Dilation of esophagus	Dilation of Esophagus	October 2012	17			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	October 2012	14	Complete	TRUE	Deleted from CPT
43458	Dilation of esophagus	Dilation of Esophagus	October 2012	17			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	October 2012	14	Complete	TRUE	Deleted from CPT
43760	Change of gastrostom	Gastrostomy Tube Repl	January 2018	11			ACEP, ACC	Deleted from CPT	CMS 000-Day Global Typically R	July 2016							FALSE			TRUE	In April 2017, the RUC note	September 2017	18	Complete	TRUE	Deleted from CPT
43762	Replacement of gastr	Gastrostomy Tube Repl	January 2018	11	January 2022	RAW	ACEP, ACC	0.75. Flag for Re-review.	CMS 000-Day Global Typically R	September 2017	000	0.75	6.23	0.23	0.13	49,049	FALSE			FALSE					TRUE	Decrease
43763	Replacement of gastr	Gastrostomy Tube Repl	January 2018	11	January 2022	RAW	ACEP, ACC	1.41. Flag for Re-review.	CMS 000-Day Global Typically R	September 2017	000	1.41	9.02	0.81	0.25	1,711	FALSE			FALSE					TRUE	Decrease
44143	Colectomy, partial; wi	RAW	January 2016	54				99214 visit appropriate. Rem	High Level E/M in Global Period	October 2015	090	27.79	NA	14.94	6.28	10,216	FALSE			FALSE					TRUE	Remove from screen
44205	Laparoscopy, surgical;	Laproscopic Procedures	October 2008	26			ACS, ASCR	Remove from screen	CMS Fastest Growing	October 2008	090	22.95	NA	11.62	4.64	12,383	FALSE			FALSE					TRUE	Remove from Screen
44207	Laparoscopy, surgical;	Laproscopic Procedures	October 2008	26			ACS, ASCR	Remove from screen	CMS Fastest Growing	February 2008	090	31.92	NA	15.07	6.16	9,951	FALSE			FALSE					TRUE	Remove from Screen
44380	Ileoscopy, through stc	Ileoscopy	October 2013	04			AGA, ASGE	0.97	MPC List	September 2011	000	0.87	4.95	0.67	0.10	2,038	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
44381	Ileoscopy, through stc	Ileoscopy	October 2013	04			AGA, ASGE	1.48	MPC List	May 2013	000	1.38	29.46	0.88	0.17	150	FALSE			FALSE		May 2013		Complete	TRUE	Decrease
44382	Ileoscopy, through stc	Ileoscopy	Ileoscopy	Ileos	October 2013	04	AGA, ASGE	1.27	MPC List	September 2011	000	1.17	7.87	0.83	0.14	1,549	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Maintain
44383	Ileoscopy, through stc	Ileoscopy	October 2013	04			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Deleted from CPT
44384	Ileoscopy, through stc	Ileoscopy	October 2013	04			AGA, ASGE	3.11	MPC List	May 2013	000	2.85	NA	1.30	0.34	124	FALSE			FALSE		May 2013		Complete	TRUE	Decrease
44385	Endoscopic evaluatior	Pouchoscopy	October 2013	05			ACG, ACS,	1.30	MPC List	September 2011	000	1.20	5.09	0.74	0.15	1,312	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
44386	Endoscopic evaluatior	Pouchoscopy	October 2013	05			ACG, ACS,	1.60	MPC List	September 2011	000	1.50	7.87	0.91	0.17	1,832	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
44388	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	2.82	MPC List	September 2011	000	2.72	6.39	1.45	0.39	4,180	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Maintain
44389	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	3.12	MPC List	September 2011	000	3.02	9.13	1.61	0.38	2,551	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Decrease
44390	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	3.82	MPC List	September 2011	000	3.74	8.05	1.97	0.41	18	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Maintain
44391	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.22	MPC List	September 2011	000	4.12	15.88	2.12	0.46	159	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Decrease
44392	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	3.63	MPC List	September 2011	000	3.53	7.58	1.76	0.49	297	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Decrease
44393	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	Deleted from CPT	MPC List	September 2011							FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Deleted from CPT
44394	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.13	MPC List	September 2011	000	4.03	8.72	2.03	0.49	2,081	FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Decrease
44397	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	Deleted from CPT	MPC List	September 2011							FALSE			TRUE	Several specific codes iden	October 2013	17	Complete	TRUE	Deleted from CPT
44401	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.44	MPC List	September 2011	000	4.34	77.43	2.24	0.46	65	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44402	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.96	MPC List	January 2014	000	4.70	NA	2.40	0.49	4	FALSE			FALSE		October 2013	17	Complete	TRUE	Decrease
44403	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	5.81	MPC List	January 2014	000	5.50	NA	2.75	0.59	76	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44404	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	3.13	MPC List	January 2014	000	3.02	9.22	1.61	0.37	190	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44405	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	3.33	MPC List	January 2014	000	3.23	13.75	1.75	0.34	57	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44406	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.41	MPC List	January 2014	000	4.10	NA	2.13	0.44	4	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44407	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	5.06	MPC List	January 2014	000	4.96	NA	2.51	0.53		FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44408	Colonoscopy through	Colonoscopy through st	January 2014	08			ASCRS, AC	4.24	MPC List	January 2014	000	4.14	NA	2.15	0.45	76	FALSE			TRUE		October 2013	17	Complete	TRUE	Decrease
44901	Incision and drainage	Drainage of Abscess	January 2013	04				Deleted from CPT	Codes Reported Together 75%	January 2012							FALSE			FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
44970	Laparoscopy, surgical,	Laproscopic Procedures	October 2008	26			ACS	Remove from screen	CMS Fastest Growing	October 2008	090	9.45	NA	6.13	2.24	22,448	FALSE			FALSE					TRUE	Remove from Screen
45170	Deleted from CPT	Rectal Tumor Excision	February 2009	11			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	September 2007							FALSE			TRUE	CPT code 45170 Excision of	October 2008	18	Code Dele	TRUE	Deleted from CPT
45171	Excision of rectal tum	Rectal Tumor Excision	February 2009	11			ACS, ASCR	8.00	Site of Service Anomaly	September 2007	090	8.13	NA	8.72	1.49	2,516	FALSE			FALSE					TRUE	Decrease
45172	Excision of rectal tum	Rectal Tumor Excision	February 2009	11			ACS, ASCR	12.00	Site of Service Anomaly	September 2007	090	12.13	NA	10.18	2.05	1,918	FALSE			FALSE					TRUE	Decrease
45300	Proctosigmoidoscopy,	Diagnostic Proctosigmo	April 2017	13			ACS, ASCR	0.80	CMS 000-Day Global Typically R	July 2016	000	0.80	2.99	0.48	0.13	23,267	FALSE			FALSE					TRUE	Maintain
45330	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	0.84	Harvard Valued - Utilization ove	April 2011	000	0.84	4.65	0.67	0.11	50,795	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45331	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	1.14	MPC List	September 2011	000	1.14	7.50	0.81	0.14	36,318	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45332	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	1.85	MPC List	September 2011	000	1.76	6.40	1.07	0.22	353	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45333	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	1.65	MPC List	September 2011	000	1.55	8.32	0.97	0.21	734	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45334	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	2.10	MPC List	September 2011	000	2.00	13.83	1.19	0.22	3,411	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45335	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	1.15	MPC List	September 2011	000	1.04	7.61	0.76	0.14	3,141	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45337	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	2.20	MPC List	September 2011	000	2.10	NA	0.99	0.26	1,691	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45338	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	2.15	MPC List	September 2011	000	2.05	6.77	1.20	0.25	5,383	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45339	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Deleted from CPT
45340	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	1.35	MPC List	September 2011	000	1.25	12.98	0.85	0.16	1,316	FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Decrease
45341	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	January 2014	09			AGA, ASGE	2.43	MPC List	September 2011	000	2.12	NA	1.25	0.23	2,713	FALSE			TRUE	Several specific codes iden	October 2013	16	Complete	TRUE	Increase
45342	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	January 2014	09			AGA, ASGE	3.08	MPC List	September 2011	000	2.98	NA	1.64	0.32	374	FALSE			TRUE	Several specific codes iden	October 2013	16	Complete	TRUE	Decrease
45345	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	May 2013		Complete	TRUE	Deleted from CPT
45346	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	2.97	MPC List	May 2013	000	2.81	76.84	1.54	0.32	1,183	FALSE			FALSE		May 2013		Complete	TRUE	Decrease
45347	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	October 2013	06			ACG, ACS,	2.98	MPC List	May 2013	000	2.72	NA	1.47	0.30	637	FALSE			FALSE		May 2013		Complete	TRUE	Decrease
45349	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	April 2014	13			AGA, ASGE	3.83	MPC List	January 2014	000	3.52	NA	1.86	0.39	632	FALSE			TRUE		October 2013	16	Complete	TRUE	Decrease
45350	Sigmoidoscopy, flexibl	Flexible Sigmoidoscopy	April 2014	13			AGA, ASGE	1.78	MPC List	January 2014	000	1.68	18.66	1.04	0.21	1,214	FALSE			TRUE		October 2013	16	Complete	TRUE	Decrease
45355	Colonoscopy, rigid or f	Colonoscopy via stoma	January 2014	08			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			FALSE	Several specific codes iden	February 2014	32	Complete	TRUE	Deleted from CPT
45378	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	3.36	CMS High Expenditure Procedur	September 2011	000	3.26	6.56	1.73	0.41	345,987	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45379	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.37	MPC List	September 2011	000	4.28	8.32	2.17	0.49	930	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45380	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	3.66	MPC List	October 2010	000	3.56	9.25	1.87	0.42	1,054,879	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45381	Colonoscopy, flexible;	Colonoscopy	January 2018	31			AGA, ASGE	3.67	CMS Fastest Growing / MPC List	October 2008	000	3.56	9.36	1.87	0.42	82,892	TRUE	Jun 2010	Yes	TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45382	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.76	MPC List	September 2011	000	4.66	16.07	2.36	0.51	24,121	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45383	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Deleted from CPT
45384	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.17	MPC List	September 2011	000	4.07	10.23	2.01	0.56	77,739	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45385	Colonoscopy, flexible;	Colonoscopy	April 2019	13			AGA, ASGE	4.57	MPC List / Codes Reported Toge	October 2010	000	4.57	8.62	2.31	0.51	971,282	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Maintain
45386	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	3.87	MPC List	September 2011	000	3.77	14.77	1.94	0.45	2,321	FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45387	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	Deleted from CPT	MPC List	September 2011							FALSE			TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Deleted from CPT
45388	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.98	MPC List	January 2014	000	4.88	79.44	2.41	0.59	26,744	FALSE			FALSE		October 2013	18	Complete	TRUE	Decrease

45389	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	5.50	MPC List	January 2014	000	5.24	NA	2.60	0.59	420	FALSE	FALSE		October 2013	18	Complete	TRUE	Decrease
45390	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	6.35	MPC List	January 2014	000	6.04	NA	2.98	0.64	23,129	FALSE	FALSE		October 2013	18	Complete	TRUE	Decrease
45391	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.95	MPC List	September 2011	000	4.64	NA	2.36	0.48	932	FALSE	TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45392	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	5.60	MPC List	September 2011	000	5.50	NA	2.74	0.63	86	FALSE	TRUE	Several specific codes iden	October 2013	18	Complete	TRUE	Decrease
45393	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.78	MPC List	January 2014	000	4.68	NA	2.10	0.59	2,112	FALSE	FALSE		October 2013	18	Complete	TRUE	Decrease
45398	Colonoscopy, flexible;	Colonoscopy	January 2014	10			AGA, ASGE	4.30	MPC List	January 2014	000	4.20	20.44	2.06	0.59	3,509	FALSE	FALSE		October 2013	18	Complete	TRUE	Decrease
46020	Placement of seton	Placement/Removal of	October 2020	16			ACS, ASCR	3.50	010-Day Global Post-Operative '	October 2019	010	3.00	4.92	3.50	0.53	1,325	FALSE	FALSE					TRUE	Increase
46030	Removal of anal setor	Placement/ Removal of	October 2020	16			ACS, ASCR	2.00	010-Day Global Post-Operative '	April 2020	010	1.26	3.09	1.17	0.21	339	FALSE	FALSE					TRUE	Increase
46200	Fissurectomy, includir	Fissurectomy	September 2007	16			ACS	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	3.59	10.05	5.72	0.62	992	FALSE	FALSE					TRUE	PE Only
46500	Injection of sclerosing	Hemorrhoid Injection	January 2018	24			ACS, ASCR	2.00	010-Day Global Post-Operative '	January 2014	010	1.74	7.52	3.53	0.26	12,575	FALSE	FALSE					TRUE	Increase
47011	Hepatotomy; for perc	Drainage of Abscess	January 2013	04				Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
47135	Liver allotransplantati	Liver Allotransplantatio	September 2014	14			ACS, ASTS	91.78	090-Day Global Post-Operative '	January 2014	090	90.00	NA	46.85	21.53	1,590	FALSE	FALSE					TRUE	Increase
47136	Liver allotransplantati	RAW	April 2014	52			ACS, ASTS	Deleted from CPT	090-Day Global Post-Operative '	April 2014							FALSE	TRUE	Identified as part of 47135	October 2014	16	Complete	TRUE	Deleted from CPT
47382	Ablation, 1 or more liv	Interventional Radiolog	October 2008	13			ACR, SIR	New PE Inputs	CMS Request - Practice Expense	NA	010	14.97	108.30	5.04	1.34	3,121	FALSE	FALSE					TRUE	PE Only
47490	Cholecystostomy, pere	Cholecystostomy	October 2009	04			ACR	4.76	CMS Fastest Growing	October 2008	010	4.76	NA	4.55	0.42	12,075	FALSE	TRUE	This service was referred to	June 2009	17	CPT Editor	TRUE	Decrease
47500	Injection procedure fc	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE	TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
47505	Injection procedure fc	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE	TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
47510	Introduction of percut	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE	TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
47511	Introduction of percut	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE	TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
47525	Change of percutaneo	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	High IWPUT	February 2008							FALSE	FALSE		February 2015	16		TRUE	Deleted from CPT
47530	Revision and/or reinse	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	February 2015							FALSE	FALSE		February 2015	16		TRUE	Deleted from CPT
47531	Injection procedure fc	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	1.30	Codes Reported Together 75% c	February 2015	000	1.30	11.26	0.62	0.13	8,621	FALSE	FALSE		February 2015	16		TRUE	Increase
47532	Injection procedure fc	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	4.50	Codes Reported Together 75% c	February 2015	000	4.25	21.37	1.49	0.42	549	FALSE	FALSE		February 2015	16		TRUE	Increase
47533	Placement of biliary d	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	5.63	Codes Reported Together 75% c	February 2015	000	5.38	31.52	1.79	0.48	1,518	FALSE	FALSE		February 2015	16		TRUE	Increase
47534	Placement of biliary d	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	7.85	Codes Reported Together 75% c	February 2015	000	7.60	33.18	2.42	0.65	4,467	FALSE	FALSE		February 2015	16		TRUE	Increase
47535	Conversion of externa	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	4.20	Codes Reported Together 75% c	February 2015	000	3.95	24.60	1.35	0.34	438	FALSE	FALSE		February 2015	16		TRUE	Increase
47536	Exchange of biliary dra	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	2.86	Codes Reported Together 75% c	February 2015	000	2.61	17.79	0.96	0.23	14,577	FALSE	FALSE		February 2015	16		TRUE	Increase
47537	Removal of biliary dra	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	1.85	Codes Reported Together 75% c	February 2015	000	1.84	12.71	0.77	0.16	1,737	FALSE	FALSE		February 2015	16		TRUE	Increase
47538	Placement of stent(s)	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	5.00	Codes Reported Together 75% c	February 2015	000	4.75	120.85	1.62	0.43	1,025	FALSE	FALSE		February 2015	16		TRUE	Increase
47539	Placement of stent(s)	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	9.00	Codes Reported Together 75% c	February 2015	000	8.75	128.69	2.55	0.82	135	FALSE	FALSE		February 2015	16		TRUE	Increase
47540	Placement of stent(s)	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	9.28	Codes Reported Together 75% c	February 2015	000	9.03	131.53	2.84	0.80	223	FALSE	FALSE		February 2015	16		TRUE	Increase
47541	Placement of access tl	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	7.00	Codes Reported Together 75% c	February 2015	000	6.75	29.20	2.22	0.64	170	FALSE	FALSE		February 2015	16		TRUE	Increase
47542	Balloon dilation of bili	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	2.85	Codes Reported Together 75% c	February 2015	ZZZ	2.85	12.52	0.82	0.25	1,346	FALSE	FALSE		February 2015	16		TRUE	Increase
47543	Endoluminal biopsy(ie	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	3.00	Codes Reported Together 75% c	February 2015	ZZZ	3.00	9.70	0.89	0.26	692	FALSE	FALSE		February 2015	16		TRUE	Increase
47544	Removal of calculi/del	Percutaneous Biliary Pr	October 2015	04		RUC	ACR, SIR	3.28	Codes Reported Together 75% c	February 2015	ZZZ	3.28	24.66	0.93	0.30	322	FALSE	TRUE	The committee noted that	February 2015	16	Complete	TRUE	Increase
47560	Laparoscopy, surgical;	RAW	October 2013	18				Deleted from CPT	CMS Request - Final Rule for 20	July 2013							FALSE	FALSE					TRUE	Maintain
47562	Laparoscopy, surgical;	RAW review	September 2014	21			ACS	Maintain work RVU and adjus	CMS High Expenditure Procedur	September 2011	090	10.47	NA	6.54	2.53	100,881	FALSE	FALSE					TRUE	Maintain
47563	Laparoscopy, surgical;	RAW review	October 2013	18				No further action. 12.11	CMS High Expenditure Procedur	September 2011	090	11.47	NA	7.04	2.75	38,983	FALSE	FALSE					TRUE	Maintain
47600	Cholecystectomy;	Cholecystectomy	April 2012	36			ACS, SAGE	20.00	CMS Request - Final Rule for 20	September 2011	090	17.48	NA	10.02	4.14	8,195	FALSE	FALSE					TRUE	Increase
47605	Cholecystectomy; witl	Cholecystectomy	April 2012	36			ACS, SAGE	21.00	CMS Request - Final Rule for 20	September 2011	090	18.48	NA	10.45	4.42	1,408	FALSE	FALSE					TRUE	Increase
48102	Biopsy of pancreas, pe	Percutaneous Needle B	September 2007	16			SIR	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	010	4.70	10.86	1.75	0.42	960	FALSE	FALSE					TRUE	PE Only
48511	External drainage, pse	Drainage of Abscess	January 2013	04				Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
49021	Drainage of peritonea	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
49041	Drainage of subdiaphr	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
49061	Drainage of retroperit	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
49080	Peritoneocentesis, ab	Peritoneocentesis	October 2010	5			ACR, AGA,	Deleted from CPT	Harvard Valued - Utilization ove	October 2009							FALSE	TRUE	The specialty reported to t	June 2010	09	Complete	TRUE	Deleted from CPT
49081	Peritoneocentesis, ab	Peritoneocentesis	October 2010	5			ACR, AGA,	Deleted from CPT	Harvard Valued - Utilization ove	February 2010							FALSE	FALSE		June 2010	09		TRUE	Deleted from CPT
49082	Abdominal paracente:	Abdominal Paracentesi:	October 2010	05			ACR, ACS,	1.35	Harvard Valued - Utilization ove	February 2010	000	1.24	5.06	0.72	0.17	11,210	FALSE	FALSE		June 2010	09		TRUE	Decrease
49083	Abdominal paracente:	Abdominal Paracentesi:	October 2010	05			ACR, ACS,	2.00	Harvard Valued - Utilization ove	February 2010	000	2.00	6.90	0.91	0.17	265,269	FALSE	FALSE		June 2010	09		TRUE	Decrease
49084	Peritoneal lavage, incl	Abdominal Paracentesi:	October 2010	05			ACR, ACS,	2.50	Harvard Valued - Utilization ove	February 2010	000	2.00	NA	0.75	0.42	1,879	FALSE	FALSE		June 2010	09		TRUE	Increase
49405	Image-guided fluid co	Drainage of Abscess	January 2013	04			ACR, SIR	4.25	Codes Reported Together 75% c	January 2012	000	4.00	22.98	1.32	0.34	5,880	FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Decrease
49406	Image-guided fluid co	Drainage of Abscess	January 2013	04			ACR, SIR	4.25	Codes Reported Together 75% c	January 2012	000	4.00	22.99	1.32	0.34	33,397	FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Decrease
49407	Image-guided fluid co	Drainage of Abscess	January 2013	04			ACR, SIR	4.50	Codes Reported Together 75% c	January 2012	000	4.25	18.03	1.36	0.42	243	FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Decrease
49418	Insertion of tunneled	Intraperitoneal Cathete	April 2010	11			ACS, ACR,	4.21	Site of Service Anomaly	February 2010	000	3.96	29.31	1.50	0.39	6,497	FALSE	FALSE		February 2010	30		TRUE	Decrease
49420	Deleted from CPT	Insertion of Intraperitoi	October 2009	40			ACS	Deleted from CPT	Site of Service Anomaly	April 2008							FALSE	TRUE	At the April 2008 RUC mee	February 2010	30	Deleted	TRUE	Deleted from CPT
49421	Insertion of tunneled	Intraperitoneal Cathete	April 2010	11			ACS, ACR,	4.21	Site of Service Anomaly	September 2007	000	4.21	NA	1.53	0.96	1,848	FALSE	TRUE	At the April 2008 RUC mee	February 2010	30	Revised	TRUE	Decrease
49422	Removal of tunneled i	Removal of Intraperitor	April 2017	14			ACS, SVS	4.00	Site of Service Anomaly - 2016	October 2016	000	4.00	NA	1.62	0.91	12,368	FALSE	FALSE					TRUE	Decrease
49505	Repair initial inguinal	RAW review	January 2012	30			ACS	Reaffirmed	CMS High Expenditure Procedur	September 2011	090	7.96	NA	5.60	1.92	50,710	FALSE	FALSE					TRUE	Maintain
49507	Repair initial inguinal	Hernia Repair	February 2011	29			ACS	10.05	Site of Service Anomaly	September 2007	090	9.09	NA	6.12	2.16	10,329	FALSE	FALSE					TRUE	Maintain
49521	Repair recurrent ingui	Hernia Repair	February 2011	29			ACS	12.44	Site of Service Anomaly	September 2007	090	11.48	NA	7.00	2.74	1,809	FALSE	FALSE					TRUE	Maintain
49560	Repair initial incisiona	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	11.92	NA	7.11	2.79	22,089	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49561	Repair initial incisiona	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	15.38	NA	8.45	3.64	12,726	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49565	Repair recurrent incisi	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	October 2019	090	12.37	NA	7.46	2.90	5,211	FALSE	TRUE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49566	Repair recurrent incisi	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	15.53	NA	8.51	3.68	3,748	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49568	Implantation of mesh	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	ZZZ	4.88	NA	1.82	1.15	27,767	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49570	Repair epigastric hern	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	6.05	NA	4.93	1.46	616	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49572	Repair epigastric hern	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	7.87	NA	5.60	1.90	451	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49580	Repair umbilical herni	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	4.47	NA	4.42	1.10		FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49582	Repair umbilical herni	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	7.13	NA	5.50	1.74	-	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49585	Repair umbilical herni	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	6.59	NA	5.10	1.56	18,847	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49587	Repair umbilical herni	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	September 2007	090	7.08	NA	5.37	1.69	7,947	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49590	Repair spigelian herni	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	8.90	NA	5.98	2.14	714	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49652	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	June 2010	090	11.92	NA	7.26	2.85	9,327	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49653	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	June 2010	090	14.94	NA	9.02	3.60	5,848	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49654	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	June 2010	090	13.76	NA	7.95	3.28	7,253	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49655	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly	June 2010	090	16.84	NA	9.73	4.03	4,804	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49656	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	15.08	NA	8.43	3.61	1,697	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49657	Laparoscopy, surgical,	Anterior Abdominal He	April 2021	09			ACS, ASCR	Deleted from CPT	Site of Service Anomaly - 2019	February 2021	090	22.11	NA	11.62	5.29	1,503	FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Deleted from CPT
49591		Anterior Abdominal He	April 2021	09			ACS, ASCR	6.27	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49592		Anterior Abdominal He	April 2021	09			ACS, ASCR	9.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49593		Anterior Abdominal He	April 2021	09			ACS, ASCR	10.80	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49594		Anterior Abdominal He	April 2021	09			ACS, ASCR	14.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49595		Anterior Abdominal He	April 2021	09			ACS, ASCR	14.88	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49596		Anterior Abdominal He	April 2021	09			ACS, ASCR	20.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49613		Anterior Abdominal He	April 2021	09			ACS, ASCR	7.75	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49614		Anterior Abdominal He	April 2021	09			ACS, ASCR	10.79	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49615		Anterior Abdominal He	April 2021	09			ACS, ASCR	12.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49616		Anterior Abdominal He	April 2021	09			ACS, ASCR	16.50	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49617		Anterior Abdominal He	April 2021	09			ACS, ASCR	16.97	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49618		Anterior Abdominal He	April 2021	09			ACS, ASCR	24.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49621		Anterior Abdominal He	April 2021	09			ACS, ASCR	14.24	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49622		Anterior Abdominal He	April 2021	09			ACS, ASCR	18.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
49623		Anterior Abdominal He	April 2021	09			ACS, ASCR	5.00	Site of Service Anomaly - 2019	February 2021							FALSE	FALSE	In October 2019, the Relati	February 2021	18	complete	TRUE	Decrease
50021	Drainage of perirenal	Drainage of Abscess	January 2013	04				Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE	FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
50080	Percutaneous nephro:	Percutaneous Nephrost	January 2020	25	January 2022	RUC	AUA	Refer to CPT	Site of Service Anomaly - 2019	October 2019	090	15.74	NA	7.75	1.82	2,659	FALSE	TRUE	In January 2020, the specia	September 2021			FALSE	
50081	Percutaneous nephro:	Percutaneous Nephrost	January 2020	25	January 2022	RUC	AUA	Refer to CPT	Site of Service Anomaly - 2019	October 2019	090	23.50	NA	10.97	2.71	5,937	FALSE	TRUE	In January 2020, the specia	September 2021			FALSE	
50200	Renal biopsy; percuta	Interventional Radiolog	October 2008	13			ACR, SIR	New PE Inputs	CMS Request - Practice Expense	NA	000	2.38	13.71	1.10	0.21	38,395	FALSE	FALSE					TRUE	PE Only

50360	Renal allotransplantat	Renal Allotransplantatio	April 2013	21		ACR, SIR	40.90	Harvard-Valued Annual Allowed	July 2012	090	39.88	NA	22.26	9.28	12,479	FALSE			FALSE						TRUE	Maintain
50387	Removal and replacen	Genitourinary Catheter	January 2015	09		ACR, SIR	2.00	Codes Reported Together 75% c	October 2012	000	1.75	15.40	0.51	0.15	7,721	FALSE			FALSE		October 2014	18	Complete	TRUE	Maintain
50392	Introduction of intrac	Genitourinary Catheter	January 2015	09		ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
50393	Introduction of ureter	Genitourinary Catheter	January 2015	09		ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
50394	Injection procedure fc	Genitourinary Catheter	January 2015	09		ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
50395	Introduction of guide	Dilation of Urinary Trac	January 2018	12		ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2014							FALSE			TRUE	In January 2015, the specia	September 2017	19	complete	TRUE	Deleted from CPT
50398	Change of nephroston	Genitourinary Catheter	January 2015	09		ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
50430	Injection procedure fc	Genitourinary Catheter	January 2015	09		ACR, SIR	3.15	Codes Reported Together 75% c	October 2014	000	2.90	15.41	1.28	0.27	1,007	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50431	Injection procedure fc	Genitourinary Catheter	January 2015	09		ACR, SIR	1.42	Codes Reported Together 75% c	October 2014	000	1.10	7.92	0.69	0.10	8,818	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50432	Placement of nephros	Dilation of Urinary Trac	January 2018	12		ACR, SIR	4.00	Codes Reported Together 75% c	October 2014	000	4.00	23.39	1.57	0.34	28,285	FALSE			FALSE		October 2014	18	Complete	TRUE	Maintain
50433	Placement of nephros	Dilation of Urinary Trac	January 2018	12			5.05	Codes Reported Together 75% c	September 2017	000	5.05	29.70	1.85	0.45	5,572	FALSE			FALSE					TRUE	Maintain
50434	Convert nephrostomy	Genitourinary Catheter	January 2015	09		ACR, SIR	4.20	Codes Reported Together 75% c	October 2014	000	3.75	24.12	1.45	0.33	2,477	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50435	Exchange nephrostom	Genitourinary Catheter	January 2015	09		ACR, SIR	2.00	Codes Reported Together 75% c	October 2014	000	1.82	16.19	0.89	0.15	46,684	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50436	Dilation of existing tra	Dilation of Urinary Trac	January 2018	12			3.37	Codes Reported Together 75% c	September 2017	000	2.78	NA	1.31	0.27	607	FALSE			FALSE					TRUE	Decrease
50437	Dilation of existing tra	Dilation of Urinary Trac	January 2018	12			5.44	Codes Reported Together 75% c	September 2017	000	4.85	NA	1.93	0.45	1,196	FALSE			FALSE					TRUE	Decrease
50542	Laparoscopy, surgical;	Laproscopic Procedures	October 2008	26		AUA	Remove from screen	CMS Fastest Growing	October 2008	090	21.36	NA	10.11	2.54	197	FALSE			FALSE					TRUE	Remove from Screen
50548	Laparoscopy, surgical;	Laproscopic Procedures	October 2008	26		AUA	Remove from screen	CMS Fastest Growing	October 2008	090	25.36	NA	10.78	3.01	2,422	FALSE			FALSE					TRUE	Remove from Screen
50590	Lithotripsy, extracorpo	Lithotripsy	April 2012	42		AUA	9.77	CMS High Expenditure Procedur	September 2011	090	9.77	11.03	5.72	1.14	54,658	FALSE			FALSE					TRUE	Maintain
50605	Ureterotomy for inser	Ureterotomy	October 2015	21	RAW	AUA, SIR	Review action plan at the RA	CMS Fastest Growing / CPT Assi	October 2008	090	16.79	NA	9.05	3.52	3,602	TRUE	Dec 2009	Yes	FALSE					TRUE	Maintain
50606	Endoluminal biopsy of	Genitourinary Catheter	April 2015	08		ACR, SIR	3.16	Codes Reported Together 75% c	October 2014	ZZZ	3.16	13.99	0.91	0.27	104	FALSE			TRUE		October 2014	18	Complete	TRUE	Increase
50693	Placement of ureteral	Genitourinary Catheter	January 2015	09		ACR, SIR	4.60	Codes Reported Together 75% c	October 2014	000	3.96	27.17	1.58	0.34	4,504	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50694	Placement of ureteral	Genitourinary Catheter	January 2015	09		ACR, SIR	6.00	Codes Reported Together 75% c	October 2014	000	5.25	29.30	1.99	0.45	981	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50695	Placement of ureteral	Genitourinary Catheter	January 2015	09		ACR, SIR	7.55	Codes Reported Together 75% c	October 2014	000	6.80	34.84	2.52	0.59	1,321	FALSE			FALSE		October 2014	18	Complete	TRUE	Increase
50705	Ureteral embolization	Genitourinary Catheter	April 2015	08		ACR, SIR	4.03	Codes Reported Together 75% c	October 2014	ZZZ	4.03	53.59	0.65	0.41	65	FALSE			TRUE		October 2014	18	Complete	TRUE	Increase
50706	Balloon dilation, urete	Genitourinary Catheter	April 2015	08		ACR, SIR	3.80	Codes Reported Together 75% c	October 2014	ZZZ	3.80	23.29	1.11	0.34	1,459	FALSE			TRUE		October 2014	18	Complete	TRUE	Increase
51040	Cystostomy, cystotom	Cystostomy	September 2007	16		AUA	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	4.49	NA	3.48	0.52	5,029	FALSE			FALSE					TRUE	PE Only
51102	Aspiration of bladder;	Urological Procedures	April 2008	45		AUA	2.70	Site of Service Anomaly	September 2007	000	2.70	4.21	1.23	0.28	14,265	FALSE			FALSE					TRUE	Decrease
51700	Bladder irrigation, sim	Bladder Catheter	January 2016	32		AUA	0.60	CMS High Expenditure Procedur	July 2015	000	0.60	1.63	0.21	0.09	194,801	FALSE			FALSE					TRUE	Decrease
51701	Insertion of non-indw	Bladder Catheter	January 2016	32		AUA	0.50	CMS High Expenditure Procedur	July 2015	000	0.50	0.78	0.18	0.06	168,108	FALSE			FALSE					TRUE	Maintain
51702	Insertion of temporar	Bladder Catheter	January 2016	32		AUA	0.50	CMS High Expenditure Procedur	July 2015	000	0.50	1.32	0.18	0.05	234,004	FALSE			FALSE					TRUE	Maintain
51703	Insertion of temporar	Bladder Catheter	January 2016	32		AUA	1.47	CMS High Expenditure Procedur	July 2015	000	1.47	2.73	0.58	0.17	54,647	FALSE			FALSE					TRUE	Maintain
51720	Bladder instillation of	Treatment of Bladder L	January 2016	33		AUA	0.87	CMS High Expenditure Procedur	July 2015	000	0.87	1.64	0.30	0.10	160,447	FALSE			FALSE					TRUE	Decrease
51726	Complex cystometrog	Urodynamic Studies	April 2009	16		AUA, ACO	1.71	Codes Reported Together 95% c	February 2008	000	1.71	7.14	NA	0.17	4,438	FALSE			TRUE	Referred to the CPT Editori	February 2009	24	Complete	TRUE	Maintain
51727	Complex cystometrog	Urodynamic Studies	April 2009	16		AUA, ACO	2.11	Codes Reported Together 95% c	February 2009	000	2.11	8.52	NA	0.22	1,982	FALSE			FALSE					TRUE	Decrease
51728	Complex cystometrog	Urodynamic Studies	April 2009	16		AUA, ACO	2.11	Codes Reported Together 95% c	February 2009	000	2.11	8.65	NA	0.19	85,150	FALSE			FALSE					TRUE	Decrease
51729	Complex cystometrog	Urodynamic Studies	April 2009	16		AUA, ACO	2.51	Codes Reported Together 95% c	February 2009	000	2.51	8.84	NA	0.27	61,880	FALSE			FALSE					TRUE	Decrease
51736	Simple uroflowmetry (	Uroflowmetry	October 2010	11		AUA	0.17	Harvard Valued - Utilization ove	February 2010	XXX	0.17	0.20	NA	0.02	10,797	FALSE			FALSE					TRUE	Decrease
51741	Complex uroflowmetr	Uroflowmetry	October 2010	11		AUA	0.17	Harvard Valued - Utilization ove	October 2009	XXX	0.17	0.21	NA	0.03	423,494	FALSE			FALSE					TRUE	Decrease
51772	Deleted from CPT	Urodynamic Studies	April 2009	16		AUA	Deleted from CPT	Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	February 2009	24	Code Dele	TRUE	Deleted from CPT
51784	Electromyography stu	Electromyography Stud	January 2019	37		AUA	0.75. Maintain, CPT Assistant	Codes Reported Together 75% c	October 2012	XXX	0.75	1.11	NA	0.07	142,000	TRUE	Feb 2014	Yes	TRUE	The Joint Workgroup refer	February 2014	34	Complete	TRUE	Decrease
51792	Stimulus evoked respo	Urinary Reflex Studies v	January 2019	37		AUA	CPT edits and CPT Assistant a	Codes Reported Together 75% c	October 2012	000	1.10	6.72	NA	0.11	7,152	TRUE	Feb 2014	Yes	TRUE	The Joint Workgroup refer	February 2014	34	Complete	TRUE	Maintain
51795	Deleted from CPT	Urology Studies	February 2008	S			Deleted from CPT	Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	February 2009	24	Code Dele	TRUE	Deleted from CPT
51797	Voiding pressure stud	Urology Studies	February 2008	S			0.80	Codes Reported Together 95% c	February 2008	ZZZ	0.80	4.66	NA	0.06	116,064	FALSE			TRUE	Referred to the CPT Editori	February 2009	24	Code Revis	TRUE	Maintain
51798	Measurement of post	Voiding Pressure Studie	April 2016	25		AUA	PE Only	CMS High Expenditure Procedur	July 2015	XXX	0.00	0.29	NA	0.01	2,169,510	FALSE			FALSE					TRUE	PE Only
52000	Cystourethroscopy (se	Cystourethroscopy	January 2016	35		AUA, ACO	1.75	MPC List / CMS High Expenditur	October 2010	000	1.53	5.21	0.63	0.17	897,375	FALSE			FALSE					TRUE	Decrease
52214	Cystourethroscopy, w	Cystourethroscopy	October 2017	19		AUA	3.50	High Volume Growth1 / CPT Ass	June 2008	000	3.50	19.06	1.20	0.42	16,853	TRUE	Aug 2009	Yes	FALSE					TRUE	Decrease
52224	Cystourethroscopy, w	Cystourethroscopy	October 2017	19		AUA	4.05	High Volume Growth1 / CPT Ass	February 2008	000	4.05	19.41	1.39	0.46	36,291	TRUE	Aug 2009	Yes	FALSE					TRUE	Increase
52234	Cystourethroscopy, w	Cystourethroscopy and	January 2021	29		AUA	4.62	Harvard Valued - Utilization ove	September 2011	000	4.62	NA	1.96	0.53	28,317	TRUE	May 2016	Yes	FALSE					TRUE	Maintain
52235	Cystourethroscopy, w	Cystourethroscopy and	October 2017	19		AUA	5.44	Harvard Valued - Utilization ove	April 2011	000	5.44	NA	2.27	0.64	33,411	TRUE	May 2016	Yes	FALSE					TRUE	Maintain
52240	Cystourethroscopy, w	Cystourethroscopy and	January 2021	29		AUA	8.75	Harvard Valued - Utilization ove	September 2011	000	7.50	NA	2.98	0.86	21,956	TRUE	May 2016	Yes	FALSE					TRUE	Decrease
52281	Cystourethroscopy, w	Cystourethroscopy	April 2010	38		AUA	2.80	Harvard Valued - Utilization ove	October 2009	000	2.75	6.79	1.33	0.32	62,618	FALSE			FALSE					TRUE	Maintain
52287	Cystourethroscopy, with injection(s) for chem		January 2020	37			Remove from Screen	High Volume Growth6	October 2019	000	3.20	7.82	1.32	0.39	51,037	FALSE			FALSE					TRUE	Remove from Screen
52332	Cystourethroscopy, w	Cystourethroscopy	April 2013	13		AUA	2.82	Harvard Valued - Utilization ove	October 2009	000	2.82	9.94	1.35	0.33	151,015	FALSE			TRUE	The Joint Workgroup recor	February 2013	15	Complete	TRUE	Maintain
52334	Cystourethroscopy wi	Dilation of Urinary Trac	January 2018	12			3.37	Codes Reported Together 75% c	September 2017	000	3.37	NA	1.54	0.39	289	FALSE			FALSE					TRUE	Decrease
52341	Cystourethroscopy; w	Urological Procedures	October 2010	65		AUA	5.35	Site of Service Anomaly	April 2008	000	5.35	NA	2.24	0.63	2,487	FALSE			FALSE					TRUE	Decrease
52342	Cystourethroscopy; w	Urological Procedures	October 2010	65		AUA	5.85	Site of Service Anomaly	April 2008	000	5.85	NA	2.41	0.68	191	FALSE			FALSE					TRUE	Decrease
52343	Cystourethroscopy; w	Urological Procedures	October 2010	65		AUA	6.55	Site of Service Anomaly	April 2008	000	6.55	NA	2.65	0.74	21	FALSE			FALSE					TRUE	Decrease
52344	Cystourethroscopy wi	Urological Procedures	October 2010	65		AUA	7.05	Site of Service Anomaly	September 2007	000	7.05	NA	2.82	0.80	3,393	FALSE			FALSE					TRUE	Decrease
52345	Cystourethroscopy wi	Urological Procedures	October 2010	65		AUA	7.55	Site of Service Anomaly	April 2008	000	7.55	NA	3.00	0.86	480	FALSE			FALSE					TRUE	Decrease
52346	Cystourethroscopy wi	Urological Procedures	October 2010	65		AUA	8.58	Site of Service Anomaly	April 2008	000	8.58	NA	3.35	0.99	212	FALSE			FALSE					TRUE	Decrease
52351	Cystourethroscopy, w	Cystourethroscopy and	September 2011	23		AUA	5.75	Harvard Valued - Utilization ove	September 2011	000	5.75	NA	2.34	0.66	22,929	FALSE			FALSE					TRUE	Decrease
52352	Cystourethroscopy, w	Cystourethroscopy and	September 2011	23		AUA	6.75	Harvard Valued - Utilization ove	September 2011	000	6.75	NA	2.72	0.77	24,811	FALSE			FALSE					TRUE	Decrease
52353	Cystourethroscopy, w	Cystourethroscopy	April 2013	13		AUA	7.50	Harvard Valued - Utilization ove	April 2011	000	7.50	NA	2.98	0.86	11,180	FALSE			TRUE	The Joint Workgroup recor	February 2013	15	Complete	TRUE	Decrease
52354	Cystourethroscopy, w	Cystourethroscopy and	September 2011	23		AUA	8.58	Harvard Valued - Utilization ove	September 2011	000	8.00	NA	3.15	0.93	9,144	FALSE			FALSE					TRUE	Increase
52355	Cystourethroscopy, w	Cystourethroscopy and	September 2011	23		AUA	10.00	Harvard Valued - Utilization ove	September 2011	000	9.00	NA	3.49	1.03	1,007	FALSE			FALSE					TRUE	Increase
52356	Cystourethroscopy, w	Cystourethroscopy	April 2013	13		AUA	8.00	Codes Reported Together 75% c	January 2013	000	8.00	NA	3.11	0.93	78,507	FALSE			FALSE					TRUE	Decrease
52400	Cystourethroscopy wi	Urological Procedures	October 2010	65		AUA	8.69	Site of Service Anomaly	September 2007	090	8.69	NA	4.19	1.00	115	FALSE			FALSE					TRUE	Decrease
52442	Cystourethroscopy, w	PE Subcommittee	October 2020	24		AUA, AAC	Maintain	PE Units Screen	April 2020	ZZZ	1.01	28.12	0.35	0.13	101,717	FALSE			FALSE					TRUE	Maintain
52500	Transurethral resectio	Urological Procedures	October 2010	65		AUA	8.14	Site of Service Anomaly	September 2007	090	8.14	NA	5.24	0.94	3,173	FALSE			FALSE					TRUE	Decrease
52601	Transurethral electros	Transurethral Electrosu	April 2016	26		AUA	13.16	Site of Service Anomaly - 2015	October 2015	090	13.16	NA	6.56	1.51	44,942	FALSE			FALSE					TRUE	Decrease
52640	Transurethral resectio	Urological Procedures	April 2008	45		AUA	4.79	Site of Service Anomaly	September 2007	090	4.79	NA	3.98	0.54	1,396	FALSE			FALSE					TRUE	Decrease
52648	Laser vaporization of p	Laser Surgery of Prostat	April 2008	57		AUA	Remove from screen	High Volume Growth1	February 2008	090	12.15	36.73	6.60	1.42	18,059	FALSE			FALSE					TRUE	Remove from Screen
53445	Insertion of inflatable	Urological Procedures	February 2011	31		AUA	13.00	Site of Service Anomaly	September 2007	090	13.00	NA	7.55	1.50	2,071	FALSE			FALSE					TRUE	Decrease
53850	Transurethral destruc	Transurethral Destructi	April 2012	43		AUA	10.08	CMS High Expenditure Procedur	September 2011	090	5.42	40.18	4.25	0.64	2,363	FALSE			FALSE					TRUE	Maintain
54405	Insertion of multi-con	Urological Procedures	April 2008	45		AUA	14.39	Site of Service Anomaly	September 2007	090	14.52	NA	7.40	1.66	5,217	FALSE			FALSE					TRUE	Maintain
54410	Removal and replacen	Urological Procedures	February 2011	31		AUA	15.18	Site of Service Anomaly	September 2007	090	15.18	NA	8.22	1.76	1,286	FALSE			FALSE					TRUE	Decrease
54520	Orchiectomy, simple (	Removal of Testical	September 2007	16		AUA	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	5.30	NA	3.61	0.68	2,671	FALSE			FALSE					TRUE	PE Only
54530	Orchiectomy, radical,	Urological Procedures	October 2010	65		AUA	8.46	Site of Service Anomaly	September 2007	090	8.46	NA	5.37	1.02	1,190	FALSE			FALSE					TRUE	Decrease
55700	Biopsy, prostate; neec	Biopsy of Prostate	January 2016	36		AUA	2.50	CMS High Expenditure Procedur	July 2015	000	2.50	4.57	1.00	0.28	156,362	FALSE			FALSE					TRUE	Decrease
55706	Biopsies, prostate, ne	RAW	April 2014	52			Maintain	010-Day Global Post-Operative '	January 2014	010	6.28	NA	3.95	0.70	2,297	FALSE			FALSE					TRUE	Maintain
55840	Prostatectomy, retropubic radical, with or wit		April 2014	31		AUA	21.36	CMS Request - Final Rule for 20	October 2013	090	21.36	NA	10.22	2.48	1,610	FALSE			FALSE					TRUE	Decrease
55842	Prostatectomy, retropubic radical, with or wit		April 2014	31		AUA	24.16	CMS Request - Final Rule for 20	October 2013	090	21.36	NA	10.24	2.52	150	FALSE			FALSE					TRUE	Decrease
55845	Prostatectomy, retrop	RAW	April 2014	31		AUA	29.07	CMS Request - Final Rule for 20	July 2013	090	25.18	NA	11.53	2.91	1,030	FALSE			FALSE					TRUE	Decrease
55866	Laparoscopy, surgical	Laparoscopic Radical Pr	April 2015	27	RUC	AUA	26.80	New Technology / CMS Fastest (	September 2007	090	26.80	NA	12.05	3.10	20,334	FALSE			TRUE	The specialty society reported that it will submit codir	Complete			TRUE	Decrease
55873	Cryosurgical ablation (	Cryoablation of Prostat	February 2009	25		AUA	13.45	CMS Request - Practice Expense	September 2007	090	13.60	171.52	7.11	1.57	1,648	FALSE			FALSE					TRUE	Decrease
56515	Destruction of lesion(s	Destruction of Lesions	September 2007	16		ACOG	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	010	3.08	4.41	2.65	0.47	3,187	FALSE			FALSE					TRUE	PE Only
56620	Vulvectomy simple; pa	Partial Removal of Vulv	February 2008	D		ACOG	7.35	Site of Service Anomaly	September 2007	090	7.53	NA	8.20	1.20	3,143	FALSE			FALSE					TRUE	Decrease
57150	Irrigation of vagina an	Vaginal Treatments	April 2017	15		ACOG	0.50	CMS 000-Day Global Typically R	July 2016	000	0.50	1.13	0.19	0.09	24,482	FALSE			FALSE					TRUE	Decrease
57155	Insertion of uterine ta	RAW	January 2017	30		ACOG, AS	5.40	Site of Service Anomaly / Differ	September 2007	000	5.15	5.80	2.64	0.43	3,111	FALSE			TRUE	ACOG conducted original s	October 2009	33	Complete	TRUE	Decrease
57156	Insertion of a vaginal i	RAW	January 2017	30		ACOG, AS	2.69	Site of Service Anomaly	September 2007	000	2.69	3.65	1.47	0.20	15,369	FALSE			FALSE		October 2009	33		TRUE	Decrease
57160	Fitting and insertion o	Vaginal Treatments	April 2017	15		ACOG	0.89	CMS 000-Day Global Typically R	July 2016	000	0.89	1.11	0.34	0.14	85,733	FALSE			FALSE					TRUE	Maintain
57240	Anterior colporrhaphy	Colporrhaphy with Cyst	January 2017	14		ACOG	10.08	Site of Service Anomaly - 2015	October 2015	090	10.08	NA	6.44	1.46	9,026	FALSE			TRUE	In October 2015, CPT code	September 2016	35	yes	TRUE	Decrease
57250	Posterior colporrhaph	Colporrhaphy with Cyst	January 2017	14		ACOG	10.08	Site of Service Anomaly - 2015	April 2016	090	10.08	NA	6.48	1.52	8,757	FALSE			TRUE	In October 2015, CPT code	September 2016	35	yes	TRUE	Decrease
57260	Combined anteropost	Colporrhaphy with Cyst	January 2017	14		ACOG	13.25	Site of Service Anomaly - 2015	April 2016	090	13.25	NA	7.67	2.00	9,740	FALSE			TRUE	In October 2015, CPT code	September 2016	35	yes	TRUE	Decrease
57265	Combined anteropost	Colporrhaphy with Cyst	January 2017	14		ACOG	15.00	Site of Service Anomaly - 2015	April 2016	090	15.00	NA	8.38	2.32	4,370	FALSE			TRUE	In October 2015, CPT code	September 2016	35	yes	TRUE	Decrease
57282	Colpopexy, vaginal; ex	Colpopexy	January 2020	26			13.48	Site of Service Anomaly - 2019	October 2019	090	11.63	NA	7.05	1.74	7,042	FALSE			FALSE					TRUE	Increase
57283	Colpopexy, vaginal; in	Colpopexy	January 2020	26			13.51	Site of Service Anomaly - 2019	October 2019	090	11.66	NA	7.11	1.79	5,777	FALSE			FALSE					TRUE	Increase

57287	Removal or revision o	Urological Procedures	February 2008	C			AUA	10.97	Site of Service Anomaly	September 2007	090	11.15	NA	8.93	1.56	1,737	FALSE		FALSE						TRUE	Decrease
57288	Sling operation for str	Sling Operation for Stre	February 2008	O			ACOG, AU	12.00	New Technology	September 2007	090	12.13	NA	7.93	1.73	25,452	FALSE		FALSE						TRUE	Decrease
57425	Laparoscopy, surgical,	Laparoscopic Colopexy	January 2020	27				18.02	Site of Service Anomaly - 2019	October 2019	090	17.03	NA	9.10	2.52	9,468	FALSE		FALSE						TRUE	Increase
58100	Endometrial sampling	Biopsy of Uterus Lining	April 2017	16			ACOG	1.21	CMS 000-Day Global Typically R	July 2016	000	1.21	1.60	0.47	0.20	68,910	FALSE		FALSE						TRUE	Decrease
58110	Endometrial sampling	Biopsy of Uterus Lining	April 2017	16			ACOG	0.77	CMS 000-Day Global Typically R	April 2017	ZZZ	0.77	0.59	0.30	0.13	672	FALSE		FALSE						TRUE	Maintain
58555	Hysteroscopy, diagnos	Hysteroscopy	January 2016	37			ACOG	3.07	CMS Request - Practice Expense	NA	000	2.65	7.57	1.38	0.43	1,494	FALSE		FALSE						TRUE	Decrease
58558	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	4.37	CMS Request - Practice Expense	NA	000	4.17	38.05	1.96	0.65	47,694	FALSE		FALSE						TRUE	Decrease
58559	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	5.54	CMS High Expenditure Procedur	July 2015	000	5.20	NA	2.35	0.81	121	FALSE		FALSE						TRUE	Decrease
58560	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	6.15	CMS High Expenditure Procedur	July 2015	000	5.75	NA	2.55	0.92	44	FALSE		FALSE						TRUE	Decrease
58561	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	7.00	CMS High Expenditure Procedur	July 2015	000	6.60	NA	2.89	1.03	2,396	FALSE		FALSE						TRUE	Decrease
58562	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	4.17	CMS Request - Practice Expense	NA	000	4.00	8.07	1.88	0.64	206	FALSE		FALSE						TRUE	Decrease
58563	Hysteroscopy, surgica	Hysteroscopy	January 2016	37			ACOG	4.62	CMS Request - Practice Expense	NA	000	4.47	59.54	2.06	0.71	2,831	FALSE		FALSE						TRUE	Decrease
58660	Laparoscopy, surgical;	Laproscopic Procedures	September 2007	16			AUA, ACO	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	11.59	NA	6.43	2.03	761	FALSE		FALSE						TRUE	PE Only
58661	Laparoscopy, surgical;	Laproscopic Procedures	September 2007	16			ACOG	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	010	11.35	NA	6.04	1.82	13,081	FALSE		FALSE						TRUE	PE Only
58823	Drainage of pelvic abs	Drainage of Abscess	January 2013	04				Deleted from CPT	Codes Reported Together 75% c	January 2012							FALSE		FALSE	Deleted nine codes that de	October 2012	06	Complete	TRUE	Deleted from CPT
59400	Routine obstetric care	Obstetrical Care	October 2009	15			ACOG, AA	32.69	High IWPUT	February 2008	MMM	36.58	NA	24.40	9.28	2,825	FALSE		FALSE						TRUE	Increase
59409	Vaginal delivery only (	Obstetrical Care	October 2009	15			ACOG, AA	14.37	High IWPUT	February 2008	MMM	14.37	NA	5.67	3.60	1,615	FALSE		FALSE						TRUE	Increase
59410	Vaginal delivery only (	Obstetrical Care	October 2009	15			ACOG, AA	18.54	High IWPUT	February 2008	MMM	18.34	NA	8.24	4.59	823	FALSE		FALSE						TRUE	Increase
59412	External cephalic vers	Obstetrical Care	October 2009	15			ACOG, AA	1.71	High IWPUT	April 2008	MMM	1.71	NA	0.83	0.47	29	FALSE		FALSE						TRUE	Maintain
59414	Delivery of placenta (s	Obstetrical Care	October 2009	15			ACOG, AA	1.61	High IWPUT	April 2008	MMM	1.61	NA	0.62	0.45	56	FALSE		FALSE						TRUE	Maintain
59425	Antepartum care only	Obstetrical Care	October 2009	15			ACOG, AA	6.31	High IWPUT	April 2008	MMM	7.80	6.63	3.05	1.96	666	FALSE		FALSE						TRUE	Decrease
59426	Antepartum care only	Obstetrical Care	October 2009	15			ACOG, AA	11.16	High IWPUT	April 2008	MMM	14.30	12.14	5.62	3.55	710	FALSE		FALSE						TRUE	Decrease
59430	Postpartum care only	Obstetrical Care	October 2009	15			ACOG, AA	2.47	High IWPUT	April 2008	MMM	3.22	3.59	1.26	0.81	1,138	FALSE		FALSE						TRUE	Increase
59510	Routine obstetric care	Obstetrical Care	October 2009	15			ACOG, AA	36.17	High IWPUT	February 2008	MMM	40.39	NA	26.09	11.12	2,365	FALSE		FALSE						TRUE	Increase
59514	Cesarean delivery only	Obstetrical Care	October 2009	15			ACOG, AA	16.13	High IWPUT	October 2008	MMM	16.13	NA	6.25	4.37	1,266	FALSE		FALSE						TRUE	Increase
59515	Cesarean delivery only	Obstetrical Care	October 2009	15			ACOG, AA	22.00	High IWPUT	April 2008	MMM	22.13	NA	10.19	6.09	760	FALSE		FALSE						TRUE	Increase
59610	Routine obstetric care	Obstetrical Care	October 2009	15			ACOG, AA	34.40	High IWPUT	April 2008	MMM	38.29	NA	24.53	10.63	89	FALSE		FALSE						TRUE	Increase
59612	Vaginal delivery only,	Obstetrical Care	October 2009	15			ACOG, AA	16.09	High IWPUT	April 2008	MMM	16.09	NA	6.14	4.48	65	FALSE		FALSE						TRUE	Increase
59614	Vaginal delivery only,	Obstetrical Care	October 2009	15			ACOG, AA	20.26	High IWPUT	April 2008	MMM	20.06	NA	8.11	5.58	36	FALSE		FALSE						TRUE	Increase
59618	Routine obstetric care	Obstetrical Care	October 2009	15			ACOG, AA	36.69	High IWPUT	April 2008	MMM	40.91	NA	26.17	11.37	22	FALSE		FALSE						TRUE	Increase
59620	Cesarean delivery only	Obstetrical Care	October 2009	15			ACOG, AA	16.66	High IWPUT	April 2008	MMM	16.66	NA	6.36	4.60	13	FALSE		FALSE						TRUE	Decrease
59622	Cesarean delivery only	Obstetrical Care	October 2009	15			ACOG, AA	22.53	High IWPUT	April 2008	MMM	22.66	NA	10.81	6.31	6	FALSE		FALSE						TRUE	Increase
60220	Total thyroid lobector	Total Thyroid Lobectom	April 2008	46			ACS, AAO-	12.29	Site of Service Anomaly	September 2007	090	11.19	NA	7.47	2.05	7,841	FALSE		FALSE						TRUE	Maintain
60225	Total thyroid lobector	Total Thyroid Lobectom	April 2008	46			ACS, AAO-	14.67	Site of Service Anomaly	September 2007	090	14.79	NA	9.89	2.66	308	FALSE		FALSE						TRUE	Maintain
60520	Thymectomy, partial c	RAW Review	January 2013	34				No reliable way to determine	CMS Request to Re-Review Fam	November 2011	090	17.16	NA	9.81	3.84	437	FALSE		FALSE						TRUE	Remove from Screen
60521	Thymectomy, partial c	RAW Review	January 2013	34				No reliable way to determine	CMS Request to Re-Review Fam	November 2011	090	19.18	NA	9.29	4.38	254	FALSE		FALSE						TRUE	Remove from Screen
60522	Thymectomy, partial c	RAW Review	January 2013	34				No reliable way to determine	CMS Request to Re-Review Fam	November 2011	090	23.48	NA	11.24	5.33	120	FALSE		FALSE						TRUE	Remove from Screen
61055	Cisternal or lateral cer	Myelography	April 2014	17				Editorial change	Codes Reported Together 75% c	January 2014	000	2.10	NA	1.06	0.34	293	FALSE		TRUE	This code change applicati	October 2013	21	Complete	TRUE	Remove from screen
61781	Stereotactic computer	Stereotactic Computer-	February 2010	13			NASS, AAN	3.75	CMS Fastest Growing	October 2009	ZZZ	3.75	NA	1.79	1.39	15,851	FALSE		FALSE		October 2009	34		TRUE	Decrease
61782	Stereotactic computer	Stereotactic Computer-	February 2010	13			NASS, AAN	3.18	CMS Fastest Growing	October 2009	ZZZ	3.18	NA	1.41	0.45	18,750	FALSE		FALSE		October 2009	34		TRUE	Decrease
61783	Stereotactic computer	Stereotactic Computer-	February 2010	13			NASS, AAN	3.75	CMS Fastest Growing	October 2009	ZZZ	3.75	NA	1.82	1.25	18,207	FALSE		FALSE		October 2009	34		TRUE	Decrease
61793	Deleted from CPT	Stereotactic Radiosurge	October 2008	26			AANS	Deleted from CPT	CMS Fastest Growing, Site of Se	September 2007							FALSE		FALSE		February 2008			TRUE	Deleted from CPT
61795	Deleted from CPT	Stereotactic Radiosurge	February 2009	38			NASS, AAC	Deleted from CPT	CMS Fastest Growing	October 2008							FALSE		TRUE	The specialty commented t	October 2009	34	Code Dele	TRUE	Deleted from CPT
61796	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				15.50	CMS Request - 2009 Final Rule	NA	090	13.93	NA	10.94	5.14	6,704	FALSE		FALSE						TRUE	Decrease
61797	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				3.48	CMS Request - 2009 Final Rule	NA	ZZZ	3.48	NA	1.68	1.29	8,122	FALSE		FALSE						TRUE	Decrease
61798	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				19.75	CMS Request - 2009 Final Rule	NA	090	19.85	NA	13.63	7.18	3,528	FALSE		FALSE						TRUE	Decrease
61799	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				4.81	CMS Request - 2009 Final Rule	NA	ZZZ	4.81	NA	2.30	1.76	570	FALSE		FALSE						TRUE	Decrease
61800	Application of stereot	Stereotactic Radiosurge	April 2008	16				2.25	CMS Fastest Growing, Site of Se	February 2008	ZZZ	2.25	NA	1.41	0.82	5,499	FALSE		FALSE						TRUE	Decrease
61885	Insertion or replacem	Vagal Nerve Stimulator	February 2010	14			AANS/CNS	6.44	Site of Service Anomaly	September 2007	090	6.05	NA	7.30	2.14	5,787	FALSE		TRUE	In Feb 2009, the specialty s	October 2009	35	Complete	TRUE	Decrease
62263	Percutaneous lysis of	Epidual Lysis	October 2010	66			AAPM, AA	6.54	Site of Service Anomaly	September 2007	010	5.00	13.40	3.59	0.45	302	FALSE		FALSE						TRUE	Maintain
62270	Spinal puncture, lumb	Lumbar Puncture	January 2019	09			ACR, ASNF	1.44	Different Performing Specialty f	October 2017	000	1.22	2.50	0.41	0.16	79,126	FALSE		TRUE	In January 2018, the RUC re	September 2018	24	Complete	TRUE	Increase
62272	Spinal puncture, thera	Lumbar Puncture	January 2019	09				1.80	Different Performing Specialty f	September 2018	000	1.58	3.31	0.65	0.34	6,301	FALSE		FALSE		September 2018	24	Complete	TRUE	Increase
62281	Injection/infusion of r	Injection of Neurolytic /	September 2007	16			ASA	Remove 99238	Site of Service Anomaly (99238-	September 2007	010	2.66	4.32	1.76	0.25	390	TRUE	Q&A May Yes	FALSE						TRUE	PE Only
62284	Injection procedure fc	Myelography	April 2014	17			ACR, ASNF	1.54	Codes Reported Together 75% c	October 2012	000	1.54	4.18	0.77	0.17	16,213	FALSE		TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Maintain
62287	Decompression proce	Percutaneous Diskector	September 2007	16			ASA	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	9.03	NA	6.85	1.07	166	FALSE		FALSE						TRUE	PE Only
62290	Injection procedure fc	Injection for discograph	April 2010	45			ASA, AAPN	3.00, CPT Assistant article pu	Different Performing Specialty f	October 2009	000	3.00	7.65	1.51	0.27	7,115	TRUE	Mar 2011 Yes	FALSE						TRUE	Maintain
62302	Myelography via lumb	Myelography	April 2014	17			ACR, ASNF	2.29	Codes Reported Together 75% c	October 2012	000	2.29	5.30	1.00	0.20	4,191	FALSE		TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Decrease
62303	Myelography via lumb	Myelography	April 2014	17			ACR, ASNF	2.29	Codes Reported Together 75% c	October 2012	000	2.29	5.43	1.00	0.20	411	FALSE		TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Decrease
62304	Myelography via lumb	Myelography	April 2014	17			ACR, ASNF	2.25	Codes Reported Together 75% c	October 2012	000	2.25	5.25	0.99	0.20	18,417	FALSE		TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Decrease
62305	Myelography via lumb	Myelography	April 2014	17			ACR, ASNF	2.35	Codes Reported Together 75% c	October 2012	000	2.35	5.82	1.03	0.20	6,616	FALSE		TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Decrease
62310	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted from CPT	CMS High Expenditure Procedur	January 2012							FALSE		TRUE	In the NPRM for 2015, CMS	May 2015	15	Complete	TRUE	Deleted from CPT
62311	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted from CPT	CMS High Expenditure Procedur	September 2011							FALSE		TRUE	In the NPRM for 2015, CMS	May 2015	15	Complete	TRUE	Deleted from CPT
62318	Injection(s), including	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted from CPT	CMS High Expenditure Procedur	January 2012							FALSE		TRUE	In the NPRM for 2015, CMS	May 2015	15	Complete	TRUE	Deleted from CPT
62319	Injection(s), including	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted from CPT	CMS High Expenditure Procedur	January 2012							FALSE		TRUE	In the NPRM for 2015, CMS	May 2015	15	Complete	TRUE	Deleted from CPT
62320	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.80	Final Rule for 2015	May 2015	000	1.80	2.89	0.87	0.22	5,631	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62321	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.95	Final Rule for 2015	May 2015	000	1.95	5.82	1.00	0.19	217,240	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62322	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.55	Final Rule for 2015	May 2015	000	1.55	2.55	0.65	0.17	42,693	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62323	Injection(s), of diagno	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.80	Final Rule for 2015	May 2015	000	1.80	5.88	0.92	0.17	699,990	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62324	Injection(s), including	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.89	Final Rule for 2015	May 2015	000	1.89	2.12	0.56	0.15	19,559	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62325	Injection(s), including	Epidural Injections	October 2015	10		RUC	AANS, AAI	2.20	Final Rule for 2015	May 2015	000	2.20	5.21	0.82	0.21	1,225	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62326	Injection(s), including	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.78	Final Rule for 2015	May 2015	000	1.78	2.31	0.58	0.15	4,644	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62327	Injection(s), including	Epidural Injections	October 2015	10		RUC	AANS, AAI	1.90	Final Rule for 2015	May 2015	000	1.90	5.78	0.92	0.19	1,995	FALSE		FALSE		May 2015	15	Complete	TRUE	Decrease
62328	Spinal puncture, lumb	Lumbar Puncture	January 2019	09				1.95	Different Performing Specialty f	September 2018	000	1.73	5.71	0.62	0.23		FALSE		FALSE		September 2018	24	Complete	TRUE	Increase
62329	Spinal puncture, thera	Lumbar Puncture	January 2019	09				2.25	Different Performing Specialty f	September 2018	000	2.03	7.22	0.82	0.44		FALSE		FALSE		September 2018	24	Complete	TRUE	Increase
62350	Implantation, revision	Intrathecal Epidural Cat	October 2010	67			AAPM, AA	6.05	Site of Service Anomaly	September 2007	010	6.05	NA	4.53	1.15	5,884	FALSE		FALSE						TRUE	Decrease
62355	Removal of previously	Intrathecal Epidural Cat	October 2010	67			AAPM, AA	4.35	Site of Service Anomaly	September 2007	010	3.55	NA	3.71	0.76	1,056	FALSE		FALSE						TRUE	Decrease
62360	Implantation or repla	Intrathecal Epidural Cat	October 2010	67			AAPMR, A	4.33	Site of Service Anomaly	April 2008	010	4.33	NA	4.12	0.99	242	FALSE		FALSE						TRUE	Decrease
62361	Implantation or repla	Intrathecal Epidural Cat	October 2010	67			AAPM, AA	5.65	Site of Service Anomaly	April 2008	010	5.00	NA	5.90	1.85	36	FALSE		FALSE						TRUE	Decrease
62362	Implantation or repla	Intrathecal Epidural Cat	October 2010	67			AAPM, AA	6.10	Site of Service Anomaly	September 2007	010	5.60	NA	4.53	1.24	8,146	FALSE		FALSE						TRUE	Decrease
62365	Removal of subcutane	Intrathecal Epidural Cat	October 2010	67			AAPMR, A	4.65	Site of Service Anomaly	September 2007	010	3.93	NA	3.88	0.93	1,266	FALSE		FALSE						TRUE	Decrease
62367	Electronic analysis of	Electronic Analysis Impl	April 2018	14			AAPM, AA	New PE inputs. 0.48	Different Performing Specialty f	October 2009	XXX	0.48	0.39	0.19	0.05	10,982	FALSE		TRUE	Identified through the Cod	October 2010	49	Complete	TRUE	Maintain
62368	Electronic analysis of	Electronic Analysis Impl	April 2018	14			AAPM, AA	New PE inputs. 0.67	Different Performing Specialty f	October 2009	XXX	0.67	0.55	0.27	0.09	43,410	FALSE		TRUE	Identified through the Cod	October 2010	49	Complete	TRUE	Decrease
62369	Electronic analysis of	Electronic Analysis Impl	April 2018	14			AAPM, AA	New PE inputs. 0.67	Codes Reported Together 75% c	October 2010	XXX	0.67	2.09	0.28	0.09	31,581	FALSE		TRUE		October 2010	49	Complete	TRUE	Decrease
62370	Electronic analysis of	Electronic Analysis Impl	April 2018	14			AAPM, AA	New PE inputs. 1.10	Codes Reported Together 75% c	October 2010	XXX	0.90	1.90	0.36	0.10	101,707	FALSE		TRUE		October 2010	49	Complete	TRUE	Decrease
63030	Laminotomy (hemilan	RAW	January 2021	29	January 2022	RUC	AANS, AA	Refer to CPT	Pre-Time Analysis / Site of Servi	January 2014	090	13.18	NA	11.67	3.96	27,404	FALSE		TRUE	CPT code 63030 was identi	September 2021			FALSE	Maintain
63042	Laminotomy (hemilan	RAW	September 2014	21			AANS, AA	Maintain work RVU and adju	Pre-Time Analysis	January 2014	090	18.76	NA	14.29	5.17	10,851	FALSE		FALSE						TRUE	Maintain
63045	Laminectomy, facetec	Laminectomy	September 2014	16		RUC Review	work ar	17.95	CMS Request - Final Rule for 20	November 2013	090	17.95	NA	14.22	5.84	10,977	FALSE		FALSE						TRUE	Maintain
63046	Laminectomy, facetec	Laminectomy	September 2014	16		RUC Review	work ar	17.25	CMS Request - Final Rule for 20	November 2013	090	17.25	NA	13.73	5.30	4,057	FALSE		FALSE						TRUE	Maintain
63047	Laminectomy, facetec	Laminectomy	January 2013	24			NASS, AAN	15.37	CMS High Expenditure Procedur	September 2011	090	15.37	NA	12.73	4.53	101,838	FALSE		FALSE						TRUE	Maintain
63048	Laminectomy, facetec	Laminectomy	January 2013	24			NASS, AAN	3.47	CMS High Expenditure Procedur	January 2012	ZZZ	3.47	NA	1.72	1.02	128,927	FALSE		FALSE						TRUE	Maintain
63056	Transpedicular approa	RAW	October 2015	21		RAW	NASS, AAN	Review action plan at RAW O	CMS Fastest Growing / CPT Assi	October 2008	090	21.86	NA	15.52	6.63	6,048	TRUE	Oct 2009 Yes	TRUE	The specialty noted that th	February 2010		Complete	TRUE	Maintain
63075	Discectomy, anterior,	Arthrodesis Including D	February 2010	5			NASS, AAN	19.60	Codes Reported Together 95% c	February 2008	090	19.60	NA	14.62	5.84	428	FALSE		TRUE	Referred to the CPT Editori	October 2009	21	Complete	TRUE	Maintain
63076	Discectomy, anterior,	Arthrodesis Including D	February 2010	5			NASS, AAN	4.04	Codes Reported Together 95% or More		ZZZ	4.04	NA	1.99	1.15	313	FALSE		FALSE		October 2009	21		TRUE	Maintain
63090	Vertebral corpectomy	Vertebral Corpectomy v	January 2017	30	October 2022	RAW	AAOS, AAI	Review action plan and addit	Codes Reported Together 75% c	January 2015	090	30.93	NA	19.02	7.77	719	FALSE		TRUE	In January 2015 the Joint C	September 2016	20	yes	FALSE	
63620	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				15.50	CMS Request - 2009 Final Rule	NA	090	15.60	NA	11.77	5.77	492	FALSE		FALSE						TRUE	Decrease
63621	Stereotactic radiosurg	Stereotactic Radiosurge	February 2009	38				4.00	CMS Request - 2009 Final Rule	NA	ZZZ	4.00	NA	1.92	1.47	160	FALSE		FALSE						TRUE	Decrease
63650	Percutaneous implant	Percutaneous implanta	October 2020	24			AAPM, AA	7.20. New PE Inputs	Site of Service Anomaly / CMS F	September 2007	010	7.15	58.56	4.24	0.76	92,083	FALSE		FALSE						TRUE	Decrease

63655	Laminectomy for impl	Neurostimulator (Spina	April 2009	17			NASS, AAN	11.43	CMS Fastest Growing	October 2008	090	10.92	NA	10.29	3.48	8,801	FALSE			FALSE						TRUE	Maintain		
63660	Deleted from CPT	Neurostimulator (Spina	April 2009	17			AAPM, AA	Deleted from CPT	Site of Service Anomaly / CMS F	September 2007							FALSE			TRUE	The RUC recommend that t	October 2008	19	Code Dele	TRUE	Deleted from CPT		
63661	Removal of spinal neu	Neurostimulator (Spina	April 2009	17			ISIS, NASS,	5.03	Site of Service Anomaly / CMS	Fastest Growing	010	5.08	14.23	3.61	0.90	3,832	FALSE			FALSE						TRUE	Decrease		
63662	Removal of spinal neu	Neurostimulator (Spina	April 2009	17			ISIS, NASS,	10.87	Site of Service Anomaly / CMS	Fastest Growing	090	11.00	NA	10.47	3.55	2,414	FALSE			FALSE						TRUE	Decrease		
63663	Revision including rep	Neurostimulator (Spina	April 2009	17			ISIS, NASS,	70	Site of Service Anomaly / CMS	Fastest Growing	010	7.75	17.85	4.47	1.04	1,584	FALSE			FALSE						TRUE	Decrease		
63664	Revision including rep	Neurostimulator (Spina	April 2009	17			ISIS, NASS,	11.39	Site of Service Anomaly / CMS	Fastest Growing	090	11.52	NA	10.73	3.76	692	FALSE			FALSE						TRUE	Decrease		
63685	Insertion or replacem	Neurostimulators	January 2021	29	January 2024	RAW	AAPM, AA	Review action plan in 2 years	Site of Service Anomaly / CMS F	September 2007	010	5.19	NA	4.42	1.07	29,921	TRUE			FALSE						FALSE	Decrease		
63688	Revision or removal o	Neurostimulators	February 2008	I			AAPM, AA	5.25	Site of Service Anomaly	September 2007	010	5.30	NA	4.54	1.13	8,593	FALSE			FALSE						TRUE	Decrease		
64405	Injection(s), anesthesi	Injection - Greater Occi	April 2017	17			AAN, AAPI	0.94	CMS 000-Day Global Typically R	July 2016	000	0.94	1.04	0.42	0.21	134,871	FALSE			FALSE						TRUE	Maintain		
64412	Injection, anesthetic a	Anesthetic Injection – S	April 2014	36			AAN, ASA,	Deleted from CPT	High Volume Growth2	April 2013							TRUE	FAQ Sept 2	Yes	TRUE	In April 2013, CPT code 64	October 2014	21	Complete	TRUE	Deleted from CPT		
64415	Injection(s), anesthetic agent(s) and/or steroi		October 2018	09	October 2021	RUC	AAPM, AS/	Refer to CPT for bundling. 1.4	CMS Fastest Growing	October 2008	000	1.35	1.89	0.38	0.11	199,150	TRUE	Dec 2011 i	Yes	TRUE	During the October 2018 R	May 2021	14	complete	FALSE	Maintain		
64416	Injection(s), anesthesi	Anesthetic Agent Nerve	October 2018	09	October 2021	RUC	ASA	Refer to CPT for bundling. Re	Site of Service Anomaly / High V	September 2007	000	1.48	NA	0.27	0.13	17,912	FALSE			TRUE	During the October 2018 R	May 2021	14	complete	FALSE	Decrease		
64417	Injection(s), anesthesi	Somatic Nerve Injectior	October 2018	09	October 2021	RUC	ASA	Refer to CPT	part of New/Revised Review	October 2018	000	1.27	2.76	0.39	0.11	15,765	FALSE			TRUE	During the October 2018 R	May 2021	14	complete	FALSE			
64418	Injection(s), anesthesi	Injection, Anesthetic Ag	April 2016	28			AAPM, AA	1.10	Harvard Valued - Utilization ove	October 2015	000	1.10	1.38	0.44	0.14	31,818	FALSE			FALSE						TRUE	Decrease		
64445	Injection(s), anesthesi	RAW	October 2017	19			AAPM, AS/	1.48	CMS Fastest Growing	October 2008	000	1.00	2.68	0.47	0.10	130,719	TRUE	Dec 2011 i	Yes	FALSE						TRUE	Maintain		
64446	Injection(s), anesthesi	Anesthetic Agent Nerve	October 2018	09	October 2021	RUC	ASA	Refer to CPT for bundling. 1.5	Site of Service Anomaly / High V	February 2008	000	1.36	NA	0.25	0.11	5,880	FALSE			TRUE	During the October 2018 R	May 2021	14	complete	FALSE	Decrease		
64447	Injection(s), anesthetic agent(s) and/or steroi		October 2018	09	October 2021	RUC	AAPM, AS/	Refer to CPT for bundling. 1.5	CMS Fastest Growing	October 2008	000	1.10	1.45	0.35	0.09	282,703	TRUE	Dec 2011 i	Yes	TRUE	During the October 2018 R	May 2021	14	complete	FALSE	Maintain		
64448	Injection(s), anesthesi	Anesthetic Agent Nerve	October 2018	09	October 2021	RUC	ASA	Refer to CPT for Bundling. Re	Site of Service Anomaly / High V	February 2008	000	1.41	NA	0.25	0.11	40,188	FALSE			TRUE	During the October 2018 R	May 2021	14	complete	FALSE	Decrease		
64449	Injection(s), anesthesi	Anesthetic Agent Nerve	April 2008	19			ASA	1.81	Site of Service Anomaly	September 2007	000	1.27	NA	0.42	0.13	1,957	FALSE			TRUE	The RUC recommended ch	February 2008	31	Complete	TRUE	Decrease		
64450	Injection(s), anesthesi	Somatic Nerve Injectior	October 2018	09			ASA, AAPN	0.75	Harvard Valued - Utilization ove	October 2009	000	0.75	1.45	0.40	0.09	467,316	TRUE	Jan 2013	Yes	FALSE						TRUE	Maintain		
64455	Injection(s), anesthesi	Injection – Digital Nerv	April 2017	18			AAOS, AOI	0.75	High Volume Growth4 / CMS 00	October 2016	000	0.75	0.62	0.18	0.05	74,450	FALSE			FALSE						TRUE	Maintain		
64470	Deleted from CPT	Injection Anesthetic Ag	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2009	28	Code Dele	TRUE	Deleted from CPT		
64472	Deleted from CPT	Injection Anesthetic Ag	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1	February 2008							FALSE			TRUE	The RUC recommended tha	February 2009	28	Code Dele	TRUE	Deleted from CPT		
64475	Deleted from CPT	Injection Anesthetic Ag	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2009	28	Code Dele	TRUE	Deleted from CPT		
64476	Deleted from CPT	Injection Anesthetic Ag	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1	April 2008							FALSE			TRUE	The RUC recommended tha	February 2009	28	Code Dele	TRUE	Deleted from CPT		
64479	Injection(s), anesthesi	Injection Anesthetic Ag	October 2009	05			AAPM, ISI	2.29	CMS Fastest Growing	October 2008	000	2.29	5.38	1.32	0.21	44,367	FALSE			TRUE	The RUC recommended tha	June 2009	19	CPT Editor	TRUE	Increase		
64480	Injection(s), anesthesi	Injection Anesthetic Ag	October 2009	05			AAPM, ISI	1.20	CMS Fastest Growing	October 2008	ZZZ	1.20	2.66	0.49	0.13	19,219	FALSE			TRUE	The RUC recommended tha	June 2009	19	CPT Editor	TRUE	Decrease		
64483	Injection(s), anesthesi	Injection of Anesthetic	October 2009	05			AAPM, ISI	1.90	CMS Fastest Growing	October 2008	000	1.90	5.26	1.18	0.17	1,044,547	FALSE			TRUE	The RUC recommended tha	June 2009	19	CPT Editor	TRUE	Decrease		
64484	Injection(s), anesthesi	Injection of Anesthetic	October 2009	05			AAPM, ISI	1.00	CMS Fastest Growing	October 2008	ZZZ	1.00	2.19	0.42	0.10	431,178	FALSE			TRUE	The Workgroup recommen	June 2009	19	CPT Editor	TRUE	Decrease		
64490	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.82	High Volume Growth1		000	1.82	3.71	1.08	0.19	265,103	FALSE			FALSE						TRUE	Decrease		
64491	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.16	High Volume Growth1		ZZZ	1.16	1.60	0.47	0.13	239,462	FALSE			FALSE						TRUE	Decrease		
64492	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.16	High Volume Growth1		ZZZ	1.16	1.61	0.50	0.13	156,746	FALSE			FALSE						TRUE	Decrease		
64493	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.52	High Volume Growth1		000	1.52	3.58	0.97	0.15	901,171	FALSE			FALSE						TRUE	Decrease		
64494	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.00	High Volume Growth1		ZZZ	1.00	1.59	0.41	0.10	809,666	FALSE			FALSE						TRUE	Decrease		
64495	Injection(s), diagnosti	Facet Joint Injections	April 2009	18			ASA, NASS	1.00	High Volume Growth1		ZZZ	1.00	1.59	0.43	0.10	456,363	FALSE			FALSE						TRUE	Decrease		
64510	Injection, anesthetic a	Fluroscopy	April 2009	27			ASA, ISIS, /	New PE inputs	CMS Request - Practice Expense	April 2009	000	1.22	3.00	0.90	0.13	6,436	FALSE			FALSE						TRUE	PE Only		
64520	Injection, anesthetic a	Fluroscopy	April 2009	27			ASA, ISIS, /	PE Review - no change	CMS Request - Practice Expense	April 2009	000	1.35	5.34	0.97	0.14	18,919	FALSE			FALSE						TRUE	PE Only		
64550	Application of surface	Percutaneous Neurosti	January 2017	29			AANS, CNS	Deleted from CPT	Final Rule for 2015	January 2017							FALSE			TRUE	In September 2016, the CP	June 2017	12	yes	TRUE	Deleted from CPT		
64553	Percutaneous implant	Percutaneous Neurosti	January 2017	15		RUC	AANS, CNS	6.13	Final Rule for 2015	July 2014	010	6.13	64.69	3.71	0.77	484	FALSE			TRUE	The RUC discussed the con	September 2016	36	yes	TRUE	Increase		
64555	Percutaneous implant	Percutaneous Neurosti	January 2019	37			AANS, CNS	5.76. Article published Jan20	High Volume Growth1 / CMS Fa	February 2008	010	5.76	58.65	3.42	0.77	3,342	TRUE	Jan 2016	Yes	TRUE	The RUC discussed the con	September 2016	36	yes	TRUE	Increase		
64561	Percutaneous implant	Percutaneous Neurosti	October 2020	24			AANS, CNS	5.44. 99214 visit appropriate.	CMS Fastest Growing / High Vol	October 2008	010	5.44	16.70	2.74	0.69	14,987	FALSE			FALSE		September 2016	36	yes	TRUE	Decrease		
64565	Percutaneous implant	Percutaneous Neurosti	January 2017	15			AANS, CNS	Deleted from CPT	Final Rule for 2015	January 2017							FALSE			FALSE		September 2016	36	yes	TRUE	Deleted from CPT		
64566	Posterior tibial neuros	Posterior Tibial Neurost	January 2019	37			ACOG, AU	0.60	CMS Request - Final Rule for 20	July 2013	000	0.60	3.05	0.21	0.09	201,680	FALSE			FALSE						TRUE	Maintain		
64568	Incision for implantati	Vagus Nerve Stimulator	February 2010	14			AANS/CNS	11.19	Site of Service Anomaly		090	9.00	NA	6.98	2.22	1,002	FALSE			FALSE		October 2009	35		TRUE	Decrease		
64573	Deleted from CPT	Neurosurgical Procedur	February 2009	28			AANS/CNS	Deleted from CPT	Site of Service Anomaly	September 2007							FALSE			TRUE	In Feb 2009, the specialty s	October 2009	35	Code Dele	TRUE	Deleted from CPT		
64581	Incision for implantati	Urological Procedures	January 2016	54			AUA	12.20. 99214 visit appropriat	Site of Service Anomaly / High L	September 2007	090	12.20	NA	5.51	1.59	10,284	FALSE			FALSE						TRUE	Decrease		
64590	Insertion or replacem	RAW	January 2018	31			ACOG, AUA		Harvard-Valued Annual Allowed	October 2012	010	2.45	5.24	1.92	0.34	12,197	FALSE			TRUE	In October 2017, this service was identified as being p			Code incor		TRUE	Remove from screen		
64615	Chemodenervation of muscle(s); muscle(s) inr		October 2020	23			AAN, AAN	Maintain	High Volume Growth6	October 2019	010	1.85	2.08	1.18	0.59	143,888	FALSE			FALSE						TRUE	Maintain		
64622	Destruction by neurol	Fluroscopy	April 2009	27			ASA, ISIS, /	PE Review - no change	CMS Request - Practice Expense	April 2008							FALSE			TRUE	The Executive Committee,	June 2008 and Feb	EC & 7	Code Dele	TRUE	Deleted from CPT		
64623	Destruction by neurol	Destruction by Neuroly	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1, Harvard	February 2008							FALSE			TRUE	The Executive Committee,	June 2008 and Feb	EC & 7	Code Dele	TRUE	Deleted from CPT		
64626	Destruction by neurol	Fluroscopy	April 2009	27			ASA, ISIS, /	PE Review - no change	CMS Request - Practice Expense	April 2008							FALSE			TRUE	The Executive Committee,	June 2008 and Feb	EC & 7	Code Dele	TRUE	Deleted from CPT		
64627	Destruction by neurol	Destruction by Neuroly	April 2008	57			ASA, NASS	Deleted from CPT	High Volume Growth1/ CMS Fas	April 2008							FALSE			TRUE	The Executive Committee,	June 2008 and Feb	EC & 7	Code Dele	TRUE	Deleted from CPT		
64633	Destruction by neurol	Destruction by Neuroly	October 2020	17			ASA, AAPN	3.42	Work Neutrality Review	September 2014	010	3.84	8.33	2.35	0.37	86,013	TRUE	February 2	Yes	TRUE	In February 2011, the CPT I	May 2015	20	complete	TRUE	Decrease		
64634	Destruction by neurol	Destruction by Neuroly	October 2020	17			ASA, AAPN	1.32	Work Neutrality Review	September 2014	ZZZ	1.32	4.21	0.53	0.13	135,589	TRUE	February 2	Yes	TRUE	In February 2011, the CPT I	May 2015	20	complete	TRUE	Maintain		
64635	Destruction by neurol	Destruction by Neuroly	October 2020	17			ASA, AAPN	3.42	Work Neutrality Review	September 2014	010	3.78	8.28	2.33	0.36	358,450	TRUE	February 2	Yes	TRUE	In February 2011, the CPT I	May 2015	20	complete	TRUE	Decrease		
64636	Destruction by neurol	Destruction by Neuroly	October 2020	17			ASA, AAPN	1.16	Work Neutrality Review	September 2014	ZZZ	1.16	3.89	0.47	0.11	539,040	TRUE	Feb 2015	Yes	TRUE	In February 2011, the CPT I	May 2015	20	complete	TRUE	Maintain		
64640	Destruction by neurol	Injection Treatment of	September 2011	25			ASAM AAF	1.23. Remove 99238.	Site of Service Anomaly (99238-	September 2007	010	1.98	5.34	1.29	0.19	184,562	FALSE			FALSE						TRUE	Decrease		
64708	Neuroplasty, major pe	Neuroplasty – Leg or Ar	October 2010	69			AOFAS, AS	6.36	Site of Service Anomaly	September 2007	090	6.36	NA	7.44	1.21	4,356	FALSE			FALSE						TRUE	Maintain		
64712	Neuroplasty, major pe	Neuroplasty – Leg or Ar	October 2009	40			AOFAS, AS	Remove from screen	Site of Service Anomaly	September 2007	090	8.07	NA	7.85	1.61	705	FALSE			TRUE	The specialty society has ic	February 2010	32	Editorial C	TRUE	Remove from Screen		
64831	Suture of digital nerve	Neurorrhaphy – Finger	October 2010	70			AAOS, ASP	9.16	Site of Service Anomaly	September 2007	090	9.16	NA	9.58	1.62	878	FALSE			FALSE						TRUE	Decrease		
65105	Enucleation of eye; wi	Ophthalmologic Proced	September 2007	16			AAO	Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	9.93	NA	16.80	0.74	835	FALSE			FALSE						TRUE	PE Only		
65205	Removal of foreign bo	Removal of Foreign Boc	April 2017	19			AAO, AOA	0.49	CMS 000-Day Global Typically R	July 2016	000	0.49	0.33	0.32	0.04	26,275	FALSE			FALSE						TRUE	Decrease		
65210	Removal of foreign bo	Removal of Foreign Boc	April 2017	19			AAO, AOA	0.75	CMS 000-Day Global Typically R	July 2016	000	0.61	0.49	0.41	0.04	25,202	FALSE			FALSE						TRUE	Decrease		
65222	Removal of foreign bo	Removal of Foreign Boc	September 2011	26			AAO, AOA	0.93	Harvard Valued - Utilization ove	April 2011	000	0.84	1.09	0.58	0.05	24,544	FALSE			FALSE						TRUE	Maintain		
65285	Repair of laceration; c	Repair of Eye Wound	February 2011	8			AAO	16.00	Site of Service Anomaly	September 2007	090	15.36	NA	15.46	1.15	704	FALSE			FALSE						TRUE	Decrease		
65780	Ocular surface recons	Ocular Reconstruction T	April 2015	31			AAO	8.80	CMS Fastest Growing / 090-Day	October 2008	090	7.81	NA	10.94	0.59	1,974	TRUE	Jun 2009	Yes	FALSE						TRUE	Decrease		
65800	Paracentesis of anteri	Paracentesis of the Eye	April 2012	21			AAO	1.53	Harvard Valued - Utilization ove	September 2011	000	1.53	1.82	0.95	0.13	20,137	FALSE			TRUE	Sept 2011 AAO stated that	October 2011	19	Complete	TRUE	Decrease		
65805	Paracentesis of anteri	Paracentesis of the Eye	April 2012	21			AAO	Deleted from CPT	Harvard Valued - Utilization ove	April 2011							FALSE			TRUE	Sept 2011 AAO stated that	October 2011	19	Complete	TRUE	Deleted from CPT		
65855	Trabeculoplasty by las	Trabeculoplasty by Lase	April 2015	11		RUC	AAO	3.00	010-Day Global Post-Operative '	January 2014	010	3.00	3.96	2.71	0.22	143,167	FALSE			TRUE	Referred to CPT to exclude	February 2015	28	Complete	TRUE	Decrease		
66170	Fistulization of sclera '	Glaucoma Surgery	April 2015	32		RUC	AAO	13.94	090-Day Global Post-Operative '	January 2014	090	13.94	NA	16.61	1.03	6,957	FALSE			FALSE						TRUE	Decrease		
66172	Fistulization of sclera '	Glaucoma Surgery	April 2015	32		RUC	AAO	14.81	090-Day Global Post-Operative '	January 2014	090	14.84	NA	18.54	1.10	3,104	FALSE			FALSE						TRUE	Decrease		
66174	Transluminal dilation '	Dilation of Aqueous Ou	January 2021	15			AAO	8.53	New Technology/ New Service	April 2010	090	12.85	NA	13.35	0.96	10,214	FALSE			TRUE	In January 2020, the RUC re	October 2020	36	complete	TRUE	Decrease		
66175	Transluminal dilation '	Dilation of Aqueous Ou	January 2021	15			AAO	10.25	New Technology/ New Service	October 2020	090	13.60	NA	13.88	1.02	223	FALSE			FALSE						TRUE	Decrease		
66179	Aqueous shunt to extr	Aqueous Shunt	January 2014	12			AAO	14.00	Harvard-Valued Annual Allowed	January 2014	090	14.00	NA	16.15	1.03	802	FALSE			TRUE		October 2013	24	Complete	TRUE	Decrease		
66180	Aqueous shunt to extr	Aqueous Shunt	January 2020	37			AAO	Maintain. 15.00	Harvard-Valued Annual Allowed	October 2012	090	15.00	NA	16.76	1.13	10,715	FALSE			TRUE	In April 2013, the Americar	October 2013	24	Complete	TRUE	Decrease		
66183	Insertion of anterior s	Aqueous Shunt	January 2020	37			AAO	Maintain. 13.20	Harvard-Valued Annual Allowed	January 2014	090	13.20	NA	15.57	0.99	4,674	FALSE			FALSE						TRUE	Maintain		
66184	Revision of aqueous s	Aqueous Shunt	January 2014	12			AAO	9.58	Harvard-Valued Annual Allowed	January 2014	090	9.58	NA	12.53	0.71	594	FALSE			TRUE		October 2013	24	Complete	TRUE	Decrease		
66185	Revision of aqueous s	Aqueous Shunt	January 2020	37			AAO	Maintain. 10.58	Harvard-Valued Annual Allowed	October 2012	090	10.58	NA	13.16	0.78	1,600	FALSE			TRUE	In April 2013, the Americar	October 2013	24	Complete	TRUE	Increase		
66711	Ciliary body destructic	Cyclophotocoagulation	January 2019	11			AAO	6.36	Codes Reported Together 75%o	October 2017	090	5.62	NA	8.58	0.43	7,616	FALSE			TRUE	In October 2017, maintaini	May 2018	26	Yes	TRUE	Decrease		
66761	Iridotomy/iridectomy	Iridotomy	January 2020	37			AAO	Maintain. 3.00	High IWPUT / 010-Day Global P	February 2008	010	3.00	5.56	3.60	0.22	67,836	FALSE			TRUE	In April 2009 the Workgrou	February 2010	33	Revised	TRUE	Decrease		
66821	Discission of secondary membranous cataract		February 2011	41			AAO	Maintain	MPC List	October 2010	090	3.42	6.06	5.36	0.25	685,933	FALSE			FALSE						TRUE	Maintain		
66982	Extracapsular cataract	Cataract Removal with	January 2021	16			AAO	10.25	High IWPUT / CMS Fastest Grow	September 2007	090	10.25	NA	10.53	0.74	159,924	TRUE	Sep 2009	Yes	FALSE						TRUE	Decrease		
66983	Intracapsular cataract	Cyclophotocoagulation	January 2019	11				Contractor Price	Codes Reported Together 75%o	January 2019	090	0.00	0.00	0.00	0.00	93	FALSE			FALSE						TRUE	Contractor Price		
66984	Extracapsular cataract	Cataract Removal with	January 2021	16			AAO	7.35	High IWPUT / MPC List / Codes	February 2008	090	7.35	NA	7.83	0.53	1,694,951	FALSE			TRUE	In October 2017, maintaini	May 2018	26	Yes	TRUE	Decrease		
66987	Extracapsular cataract	Cataract Removal with	January 2021	16			AAO	13.15	Codes Reported Together 75%o	January 2019	090	0.00	0.00	0.00	0.00		FALSE			FALSE						TRUE	Decrease		
66988	Extracapsular cataract	Cyclophotocoagulation	January 2019	11				10.25	Codes Reported Together 75%o	January 2019	090	0.00	0.00	0.00	0.00		FALSE			FALSE						TRUE	Decrease		
66989		Cataract Removal with	January 2021	16			AAO	12.13	High Volume Category III Codes	January 2021							FALSE			FALSE	At the April 2019 RUC mee	October 2020	37	complete	TRUE	Maintain		
66991		Cataract Removal with	January 2021	16			AAO	9.23	High Volume Category III Codes	January 2021							FALSE			FALSE	At the April 2019 RUC mee	October 2020	37	complete	TRUE	Maintain		
67028	Intravitreal injection c	Treatment of Retinal Le	April 2019	14			AAO, ASRS	1.44	High Volume Growth1 / CMS Fa	February 2008	000	1.44	1.75	1.11	0.11	3,868,836	FALSE			FALSE						TRUE	Maintain		
67036	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	12.13	Harvard-Valued Annual Allowed	October 2012	090	12.13	NA	12.84	0.92	18,016	FALSE			FALSE						TRUE	Decrease		
67038	Deleted from CPT	Ophthalmological Proce	September 2007	16			AAO	Deleted from CPT	Site of Service Anomaly	September 2007							FALSE			FALSE		February 2007				TRUE	Deleted from CPT		
67039	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	13.20	Site of Service Anomaly (99238-	September 2007	090	13.20	NA	13.50	0.99	3,357	FALSE			FALSE						TRUE	Decrease		
67040	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	14.50	Site of Service Anomaly (99238-	September 2007	090	14.50	NA	14.31	1.10	8,666	FALSE			FALSE						TRUE	Decrease		
67041	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	16.33	Harvard-Valued Annual Allowed	October 2012	090	16.33	NA	15.44	1.24	13,146	FALSE			FALSE						TRUE	Decrease		
67042	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	16.33	Harvard-Valued Annual Allowed	October 2012	090	16.33	NA	15.44	1.24	26,972	FALSE			FALSE						TRUE	Decrease		
67043	Vitrectomy, mechanic	Vitrectomy	October 2013	11			AAO	17.40	Harvard-Valued Annual Allowed	October 2012	090	17.40	NA	16.10	1.30	373	FALSE			FALSE						TRUE	Decrease		
67101	Repair of retinal detac	Retinal Detachment Re	October 2015	11		RUC	AAO, ASRS	3.50	090-Day Global Post-Operative '	April 2015	010	3.50	5.95	4.45	0.26	343	FALSE			TRUE	In April 2015, the RUC reco	May 2015	21	Complete	TRUE	Decrease		

67105	Repair of retinal detac	Retinal Detachment Re	October 2015	11		RUC	AAO, ASRS	3.84	090-Day Global Post-Operative \	April 2015	010	3.39	4.98	4.29	0.25	3,778	FALSE			TRUE	In April 2015, the RUC reco	May 2015	21	Complete	TRUE	Decrease
67107	Repair of retinal detac	Retinal Detachment Re	April 2015	12			AAO	16.00. Reduce 99238 to 0.5	Site of Service Anomaly (99238-	September 2007	090	16.00	NA	15.23	1.19	623	FALSE			FALSE	CPT codes 67108 amd 6711	October 2014	23		TRUE	Decrease
67108	Repair of retinal detac	Retinal Detachment Re	April 2015	12		RUC	AAO	17.13	Site of Service Anomaly (99238-	September 2007	090	17.13	NA	15.93	1.28	16,523	FALSE			FALSE	CPT codes 67108 amd 6711	October 2014	23		TRUE	Decrease
67110	Repair of retinal detac	Retinal Detachment Re	April 2015	12			AAO	10.25. Remove 99238	Site of Service Anomaly (99238-	September 2007	090	10.25	14.89	12.46	0.75	2,305	FALSE			FALSE	CPT codes 67108 amd 6711	October 2014	23		TRUE	Maintain
67112	Repair of retinal detac	Retinal Detachment Re	April 2015	12			AAO	Deleted from CPT	090-Day Global Post-Operative \	April 2014							FALSE			TRUE	Added as part of the family	October 2014	23	Complete	TRUE	Deleted from CPT
67113	Repair of complex reti	Retinal Detachment Re	April 2015	12		RUC	AAO	19.00	090-Day Global Post-Operative \	January 2014	090	19.00	NA	17.96	1.44	12,384	FALSE			FALSE	CPT codes 67108 amd 6711	October 2014	23	Complete	TRUE	Decrease
67141	Prophylaxis of retinal	Retinal Detachment Prc	October 2020	08			AAO, ASRS	2.53	Harvard Valued - Utilization ove	January 2020	090	6.15	8.63	7.41	0.45	1,395	FALSE			TRUE	CPT code 67145 was identi	May 2020		complete	TRUE	Decrease
67145	Prophylaxis of retinal	Retinal Detachment Prc	October 2020	08			AAO, ASRS	2.53	Harvard Valued - Utilization ove	October 2019	090	6.32	8.51	7.52	0.47	31,865	FALSE			TRUE	CPT code 67145 was identi	May 2020		Complete	TRUE	Decrease
67210	Destruction of localize	Treatment of Retinal Le	October 2010	13			AAO	6.36	High IWPUT	February 2008	090	6.36	8.14	7.54	0.47	56,884	FALSE			TRUE	Code originally referred to CPT with request for globa			Complete	TRUE	Decrease
67220	Destruction of localize	Treatment of Retinal Le	October 2010	13			AAO	6.36	High IWPUT	February 2008	090	6.36	8.62	7.54	0.47	3,636	FALSE			TRUE	Code originally referred to CPT with request for globa			Complete	TRUE	Decrease
67225	Destruction of localize	Photodynamic Therapy	February 2008	P			AAO	0.47	New Technology	September 2007	ZZZ	0.47	0.34	0.29	0.04	168	FALSE			FALSE					TRUE	Maintain
67228	Treatment of extensiv	Treatment of Retinal Le	October 2009	40			AAO	Remove from screen	High IWPUT	February 2008	010	4.39	5.16	4.04	0.33	62,152	FALSE			FALSE					TRUE	Remove from Screen
67255	Scleral reinforcement	Aqueous Shunt	January 2014	12			AAO	10.17	Harvard-Valued Annual Allowed	January 2014	090	8.38	NA	10.83	0.64	833	FALSE			TRUE		October 2013	24	Complete	TRUE	Maintain
67311	Strabismus surgery, re	Strabismus Surgery	October 2020	18			AAO, AAP	5.93	ZZZ Global Post-Operative Visits	April 2020	090	7.77	NA	8.90	0.59	4,955	FALSE			FALSE					TRUE	Decrease
67312	Strabismus surgery, re	Strabismus Surgery	October 2020	18			AAO, AAP	9.50	ZZZ Global Post-Operative Visits	April 2020	090	9.66	NA	10.47	0.74	1,514	FALSE			FALSE					TRUE	Decrease
67314	Strabismus surgery, re	Strabismus Surgery	October 2020	18			AAO, AAP	5.93	ZZZ Global Post-Operative Visits	April 2020	090	8.79	NA	10.32	0.65	2,533	FALSE			FALSE					TRUE	Decrease
67316	Strabismus surgery, re	Strabismus Surgery	October 2020	18			AAO, AAP	10.31	ZZZ Global Post-Operative Visits	April 2020	090	10.93	NA	11.62	0.80	168	FALSE			FALSE					TRUE	Decrease
67318	Strabismus surgery, ar	Strabismus Surgery	October 2020	18			AAO, AAP	9.80	ZZZ Global Post-Operative Visits	April 2020	090	9.12	NA	10.86	0.68	205	FALSE			FALSE					TRUE	Decrease
67320	Transposition proced	Strabismus Surgery	October 2020	18			AAO, AAP	3.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.40	NA	3.31	0.42	362	FALSE			FALSE					TRUE	Decrease
67331	Strabismus surgery on	Strabismus Surgery	October 2020	18			AAO, AAP	2.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.13	NA	3.15	0.39	902	FALSE			FALSE					TRUE	Decrease
67332	Strabismus surgery on	Strabismus Surgery	October 2020	18			AAO, AAP	3.50	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.56	NA	3.41	0.43	1,753	FALSE			FALSE					TRUE	Decrease
67334	Strabismus surgery by	Strabismus Surgery	October 2020	18			AAO, AAP	2.06	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.05	NA	3.11	0.38	128	FALSE			FALSE					TRUE	Decrease
67335	Placement of adjustat	Strabismus Surgery	October 2020	18			AAO, AAP	3.23	ZZZ Global Post-Operative Visits	October 2019	ZZZ	2.49	NA	1.52	0.19	1,681	FALSE			FALSE					TRUE	Increase
67340	Strabismus surgery im	Strabismus Surgery	October 2020	18			AAO, AAP	5.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	6.00	NA	3.71	0.45	88	FALSE			FALSE					TRUE	Decrease
67500	Retrobulbar injection;	Injection – Eye	October 2017	11			AAO, ASRS	1.18	CMS 000-Day Global Typically R	October 2017	000	1.18	0.91	0.52	0.09	7,903	FALSE			FALSE					TRUE	Decrease
67505	Retrobulbar injection;	Injection – Eye	October 2017	11			AAO, ASRS	1.18	CMS 000-Day Global Typically R	October 2017	000	1.18	1.26	0.82	0.09	140	FALSE			FALSE					TRUE	Decrease
67515	Injection of medicatio	Injection – Eye	October 2017	11			AAO, ASRS	0.84	CMS 000-Day Global Typically R	July 2016	000	0.75	0.69	0.56	0.05	24,360	FALSE			FALSE					TRUE	Decrease
67820	Correction of trichiasi	Correction of Trichiasis	April 2016	29			AOA, AOA	0.32	CMS High Expenditure Procedur	July 2015	000	0.32	0.27	0.31	0.02	222,157	FALSE			FALSE					TRUE	Decrease
67914	Repair of ectropion; si	Repair of Eyelid	April 2013	24			AAO	3.75	Harvard-Valued Annual Allowed	October 2012	090	3.75	10.51	5.40	0.30	1,601	FALSE			FALSE					TRUE	Maintain
67915	Repair of ectropion; tl	Repair of Eyelid	April 2013	24			AAO	2.03	Harvard-Valued Annual Allowed	October 2012	090	2.03	7.26	3.54	0.15	332	FALSE			FALSE					TRUE	Decrease
67916	Repair of ectropion; e	Repair of Eyelid	April 2013	24			AAO	5.48	Harvard-Valued Annual Allowed	October 2012	090	5.48	12.24	6.46	0.45	1,895	FALSE			FALSE					TRUE	Maintain
67917	Repair of ectropion; e	Repair of Eyelid	April 2013	24			AAO	5.93	Harvard-Valued Annual Allowed	October 2012	090	5.93	12.07	6.75	0.47	24,678	FALSE			FALSE					TRUE	Decrease
67921	Repair of entropion; s	Repair of Eyelid	April 2013	24			AAO	3.47	Harvard-Valued Annual Allowed	October 2012	090	3.47	10.56	5.25	0.26	3,614	FALSE			FALSE					TRUE	Maintain
67922	Repair of entropion; t	Repair of Eyelid	April 2013	24			AAO	2.03	Harvard-Valued Annual Allowed	October 2012	090	2.03	6.95	3.52	0.15	100	FALSE			FALSE					TRUE	Decrease
67923	Repair of entropion; e	Repair of Eyelid	April 2013	24			AAO	5.48	Harvard-Valued Annual Allowed	October 2012	090	5.48	12.25	6.48	0.43	1,300	FALSE			FALSE					TRUE	Decrease
67924	Repair of entropion; e	Repair of Eyelid	April 2013	24			AAO	5.93	Harvard-Valued Annual Allowed	October 2012	090	5.93	12.90	6.76	0.46	11,149	FALSE			FALSE					TRUE	Maintain
68040	Expression of conjunc	Treatment of Eyelid Les	September 2011	51			AAO	Revised parenthetical	High Volume Growth1	February 2008	000	0.85	0.91	0.49	0.04	6,702	FALSE			TRUE	AAO to develop CPT Assist	February 2013	18	Complete	TRUE	Maintain
68200	Subconjunctival inject	Subconjunctival Injectic	October 2013	18			AAO	0.49	Harvard Valued - Utilization ove	April 2011	000	0.49	0.68	0.46	0.04	8,059	FALSE			FALSE					TRUE	Maintain
68801	Dilation of lacrimal pu	Dilation and Probing of	January 2015	23			AAO, AOA	1.00	010-Day Global Post-Operative \	January 2014	010	0.82	1.91	1.39	0.05	27,980	FALSE			FALSE					TRUE	Maintain
68810	Probing of nasolacrim	Dilation and Probing of	January 2015	23			AAO, AOA	1.54	Site of Service Anomaly / 010-D	September 2007	010	1.54	3.07	2.02	0.13	28,019	FALSE			FALSE					TRUE	Decrease
68811	Probing of nasolacrimal duct, with or without		January 2015	23			AAO, AOA	2.03	010-Day Global Post-Operative \	September 2014	010	1.74	NA	2.01	0.14	451	FALSE			FALSE					TRUE	Decrease
68815	Probing of nasolacrim	Dilation and Probing of	January 2015	23			AAO, AOA	3.00	010-Day Global Post-Operative \	January 2014	010	2.70	8.61	3.49	0.21	8,129	FALSE			FALSE					TRUE	Decrease
68816	Probing of nasolacrimal duct, with or without		January 2015	23			AAO, AOA	2.35	010-Day Global Post-Operative \	September 2014	010	2.10	23.29	2.26	0.16	248	FALSE			FALSE					TRUE	Decrease
69100	Biopsy external ear	Biopsy of Ear	April 2009	28			AAD	0.81	CMS Fastest Growing	October 2008	000	0.81	2.01	0.46	0.09	164,973	FALSE			FALSE					TRUE	Maintain
69200	Removal foreign body	Removal of Foreign Boc	September 2011	29			AAO-HNS	0.77	Harvard Valued - Utilization ove	April 2011	000	0.77	1.51	0.49	0.11	59,479	FALSE			FALSE					TRUE	Maintain
69210	Removal impacted cer	Removal of Cerumen	January 2015	29			AAFP, AAC	0.58.	CMS High Expenditure Procedur	September 2011	000	0.61	0.69	0.27	0.09	1,589,620	FALSE			TRUE	In January 2012, the RUC re	October 2012	19	Complete	TRUE	Decrease
69400	Eustachian tube inflat	Eustachian Tube Proce	October 2013	18			AAO-HNS	Deleted from CPT	High Volume Growth2	October 2013							FALSE			TRUE	October 2013, the RUC rec	February 2014	41	Complete	TRUE	Deleted from CPT
69401	Eustachian tube inflat	Eustachian Tube Proce	October 2013	18			AAO-HNS	Deleted from CPT	High Volume Growth2	April 2013							FALSE			TRUE	October 2013, the RUC rec	February 2014	41	Complete	TRUE	Deleted from CPT
69405	Eustachian tube cathe	Eustachian Tube Proce	October 2013	18			AAO-HNS	Deleted from CPT	High Volume Growth2	October 2013							FALSE			TRUE	October 2013, the RUC rec	February 2014	41	Complete	TRUE	Deleted from CPT
69433	Tympanostomy (requi	Tympanostomy	September 2011	30			AAO-HNS	1.57	Harvard Valued - Utilization ove	April 2011	010	1.57	4.15	2.03	0.21	48,248	FALSE			FALSE					TRUE	Maintain
69801	Labyrinthotomy, with	Labyrinthotomy	October 2015	21			AAO-HNS	Review action plan at RAW O	CMS Fastest Growing / Site of S	September 2007	000	2.06	4.22	1.26	0.27	24,321	TRUE	May 2011	Yes	TRUE	The Workgroup previously	Feb 2010	34	Revised	TRUE	Decrease
69802	Labyrinthotomy, with	Labryinthotomy	April 2010	16			AAO-HNS	Deleted from CPT	CMS Fastest Growing / Site of S	Service Anomaly (99238-Only)							FALSE			TRUE	Prior to surveying this serv	Feburary 2011	25	Code Dele	TRUE	Deleted from CPT
69930	Cochlear device impla	Cochlear Device Implan	February 2008	M			AAO-HNS	17.60	Site of Service Anomaly	September 2007	090	17.73	NA	15.81	2.44	4,267	FALSE			FALSE					TRUE	Maintain
70030	Radiologic examinatio	X-Ray of Eye	January 2020	28				0.18	CMS-Other - Utilization over 20,	January 2019	XXX	0.18	0.74	NA	0.02	23,756	FALSE			FALSE					TRUE	Increase
70100	Radiologic examinatio	RAW	October 2013	18				RUC to submit letter to CMS	High Volume Growth2	April 2013	XXX	0.18	0.92	NA	0.02	20,165	FALSE			FALSE					TRUE	Maintain
70210	Radiologic examinatio	X-Ray Exam - Sinuses	January 2019	24			AAFP, ACP	0.20	CMS-Other - Utilization over 30,	October 2017	XXX	0.17	0.75	NA	0.02	31,748	FALSE			FALSE					TRUE	Increase
70220	Radiologic examinatio	X-Ray Exam - Sinuses	January 2019	24			AAFP, ACP	0.22	CMS-Other - Utilization over 30,	October 2017	XXX	0.22	0.86	NA	0.02	59,212	FALSE			FALSE					TRUE	Decrease
70250	Radiologic examinatio	X-Ray Exam – Skull	January 2019	25			ACR, ASNR	0.20	CMS-Other - Utilization over 30,	October 2017	XXX	0.18	0.84	NA	0.02	45,019	FALSE			FALSE					TRUE	Decrease
70260	Radiologic examinatio	X-Ray Exam – Skull	January 2019	25			ACR, ASNR	0.29	CMS-Other - Utilization over 30,	October 2017	XXX	0.28	1.01	NA	0.02	9,622	FALSE			FALSE					TRUE	Decrease
70310	Radiologic examinatio	RAW	October 2013	18				RUC to submit letter to CMS	High Volume Growth2	April 2013	XXX	0.16	0.95	NA	0.02	2,217	FALSE			FALSE					TRUE	Maintain
70360	Radiologic examinatio	X-Ray Exam – Neck	January 2019	26			AAFP, ACP	0.20	CMS-Other - Utilization over 30,	October 2017	XXX	0.18	0.72	NA	0.02	64,675	FALSE			FALSE					TRUE	Increase
70371	Complex dynamic pha	Laryngography	January 2019	37			ACR, AAFP	CPT Assistant article publishe	Codes Reported Together 75% c	October 2012	XXX	0.84	2.31	NA	0.06	1,976	TRUE	July 2014	Yes	FALSE					TRUE	Maintain
70373	Laryngography, contra	Laryngography	October 2012				ACR, AAFP	CPT Assistant article publishe	Codes Reported Together 75% c	October 2012							TRUE	July 2014	Yes	FALSE					TRUE	Maintain
70450	Computed tomograph	CT Head/Brain	April 2019	15			ACR, ASNR	0.85	CMS-Other - Utilization over 50(	April 2011	XXX	0.85	2.43	NA	0.05	5,711,912	FALSE			FALSE					TRUE	Maintain
70460	Computed tomograph	CT Head/Brain	April 2019	15			ACR, ASNR	1.13	CMS High Expenditure Procedur	April 2013	XXX	1.13	3.49	NA	0.06	28,050	FALSE			FALSE					TRUE	Maintain
70470	Computed tomograph	CT Head/Brain	April 2019	15			ACR, ASNR	1.27	Harvard Valued - Utilization ove	October 2009	XXX	1.27	4.17	NA	0.06	92,135	FALSE			FALSE					TRUE	Maintain
70480	Computed tomograph	CT – Orbit/Ear/Fossa	October 2018	16			ACR, ASNR	1.28	CMS-Other - Utilization over 30,	October 2017	XXX	1.28	3.64	NA	0.06	54,791	FALSE			FALSE					TRUE	Maintain
70481	Computed tomograph	CT – Orbit/Ear/Fossa	October 2018	16			ACR, ASNR	1.13	CMS-Other - Utilization over 30,	October 2017	XXX	1.13	4.56	NA	0.06	10,929	FALSE			FALSE					TRUE	Decrease
70482	Computed tomograph	CT – Orbit/Ear/Fossa	October 2018	16			ACR, ASNR	1.27	CMS-Other - Utilization over 30,	October 2017	XXX	1.27	5.42	NA	0.07	4,917	FALSE			FALSE					TRUE	Decrease
70486	Computed tomograph	CT – Maxillofacial	April 2014	41			ACR, ASNR	0.85	CMS-Other - Utilization over 25(	April 2013	XXX	0.85	3.13	NA	0.05	532,110	FALSE			FALSE					TRUE	Decrease
70487	Computed tomograph	CT – Maxillofacial	April 2014	41			ACR, ASNR	1.17	CMS-Other - Utilization over 25(	April 2014	XXX	1.13	3.62	NA	0.06	30,559	FALSE			FALSE					TRUE	Decrease
70488	Computed tomograph	CT – Maxillofacial	April 2014	41			ACR, ASNR	1.30	CMS-Other - Utilization over 25(	April 2014	XXX	1.27	4.56	NA	0.06	3,505	FALSE			FALSE					TRUE	Decrease
70490	Computed tomograph	CT Soft Tissue Neck	January 2017	21			ACR, ASNR	1.28	CMS High Expenditure Procedur	July 2015	XXX	1.28	3.38	NA	0.06	68,230	FALSE			FALSE					TRUE	Maintain
70491	Computed tomograph	CT Soft Tissue Neck	January 2017	21			ACR, ASNR	1.38	CMS High Expenditure Procedur	July 2015	XXX	1.38	4.41	NA	0.06	279,888	FALSE			FALSE					TRUE	Maintain
70492	Computed tomograph	CT Soft Tissue Neck	January 2017	21			ACR, ASNR	1.62	CMS High Expenditure Procedur	July 2015	XXX	1.62	5.37	NA	0.10	25,867	FALSE			FALSE					TRUE	Increase
70496	Computed tomograph	CT Angiography – Head	January 2019	37			ACR, ASNR	1.75	High Volume Growth1 / CMS Fa	February 2008	XXX	1.75	6.80	NA	0.11	525,192	FALSE			FALSE					TRUE	Maintain
70498	Computed tomograph	CT Angiography – Head	January 2019	37			ACR, ASNR	1.75	High Volume Growth1 / CMS Fa	February 2008	XXX	1.75	6.79	NA	0.11	546,880	FALSE			FALSE					TRUE	Maintain
70540	Magnetic resonance (r	MRI Face and Neck	January 2016	39			ACR, ASNR	1.35	CMS High Expenditure Procedur	July 2015	XXX	1.35	6.02	NA	0.07	10,325	FALSE			FALSE					TRUE	Maintain
70542	Magnetic resonance (r	MRI Face and Neck	January 2016	39			ACR, ASNR	1.62	CMS High Expenditure Procedur	July 2015	XXX	1.62	7.14	NA	0.11	993	FALSE			FALSE					TRUE	Maintain
70543	Magnetic resonance (r	MRI Face and Neck	January 2016	39			ACR, ASNR	2.15	CMS High Expenditure Procedur	July 2015	XXX	2.15	8.88	NA	0.12	61,843	FALSE			FALSE					TRUE	Maintain
70544	Magnetic resonance a	Magnetic Resonance Ar	October 2016	18		RUC	ACR, ASNR	1.20	CMS High Expenditure Procedur	July 2015	XXX	1.20	5.71	NA	0.07	247,119	FALSE			FALSE					TRUE	Maintain
70545	Magnetic resonance a	Magnetic Resonance Ar	October 2016	18		RUC	ACR, ASNR	1.20	CMS High Expenditure Procedur	July 2015	XXX	1.20	6.08	NA	0.07	3,638	FALSE			FALSE					TRUE	Maintain
70546	Magnetic resonance a	Magnetic Resonance Ar	October 2016	18		RUC	ACR, ASNR	1.48	CMS High Expenditure Procedur	July 2015	XXX	1.48	9.09	NA	0.10	18,220	FALSE			FALSE					TRUE	Decrease
70547	Magnetic resonance a	Magnetic Resonance Ar	October 2016	19		RUC	ACR, ASNR	1.20	CMS High Expenditure Procedur	July 2015	XXX	1.20	5.74	NA	0.07	78,876	FALSE			FALSE					TRUE	Maintain
70548	Magnetic resonance a	Magnetic Resonance Ar	October 2016	19		RUC	ACR, ASNR	1.50	CMS High Expenditure Procedur	July 2015	XXX	1.50	6.32	NA	0.08	17,524	FALSE			FALSE					TRUE	Increase
70549	Magnetic resonance a	Magnetic Resonance Ar	October 2016	19		RUC	ACR, ASNR	1.80	CMS High Expenditure Procedur	July 2015	XXX	1.80	9.27	NA	0.13	58,959	FALSE			FALSE					TRUE	Maintain
70551	Magnetic resonance (r	MRI-Brain	January 2013	26			ACR, ASNR	1.48	CMS High Expenditure Procedur	September 2011	XXX	1.48	4.76	NA	0.08	1,166,152	FALSE			FALSE					TRUE	Maintain
70552	Magnetic resonance (r	MRI-Brain	January 2013	26			ACR, ASNR	1.78	CMS High Expenditure Procedur	September 2011	XXX	1.78	6.91	NA	0.11	21,951	FALSE			FALSE					TRUE	Maintain
70553	Magnetic resonance (r	MRI-Brain	January 2013	26			ACR, ASNR	2.36	CMS-Other - Utilization over 50(	April 2011	XXX	2.29	7.97	NA	0.13	1,005,264	FALSE			FALSE					TRUE	Maintain
71010	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	Low Value-High Volume / CMS H	October 2010							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71015	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71020	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	MPC List / CMS High Expenditur	October 2010							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71021	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71022	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71023	Radiologic examinatio	Chest X-Ray	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71030	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71034	Radiologic examinatio	Chest X-Rays	April 2016	07			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT

71035	Radiologic examinatio	Chest X-Rays	April 2016	07		ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE			FALSE		February 2016	20	Complete	TRUE	Deleted from CPT
71045	Radiologic examinatio	Chest X-Ray	April 2016	07		ACR	0.18	CMS High Expenditure Procedur	February 2016	XXX	0.18	0.55	NA	0.02	15,582,853	FALSE			FALSE		February 2016	20	Complete	TRUE	Decrease
71046	Radiologic examinatio	Chest X-Ray	April 2016	07		ACR	0.22	CMS High Expenditure Procedur	February 2016	XXX	0.22	0.74	NA	0.02	10,465,557	FALSE			FALSE		February 2016	20	Complete	TRUE	Decrease
71047	Radiologic examinatio	Chest X-Ray	April 2016	07		ACR	0.27	CMS High Expenditure Procedur	February 2016	XXX	0.27	0.95	NA	0.02	15,324	FALSE			FALSE		February 2016	20	Complete	TRUE	Decrease
71048	Radiologic examinatio	Chest X-Ray	April 2016	07		ACR	0.31	CMS High Expenditure Procedur	February 2016	XXX	0.31	1.00	NA	0.02	10,897	FALSE			FALSE		February 2016	20	Complete	TRUE	Decrease
71090	Insertion pacemaker,	Insertion/Removal of P	April 2011	10		ACC	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete	TRUE	Deleted from CPT
71100	Radiologic examinatio	X-Ray of Ribs	April 2016	30		ACR	0.22	CMS-Other - Utilization over 25(	April 2013	XXX	0.22	0.83	NA	0.02	174,554	FALSE			FALSE					TRUE	Maintain
71101	Radiologic examinatio	X-Ray of Ribs	April 2016	30		ACR	0.27	CMS-Other - Utilization over 25(	October 2015	XXX	0.27	0.94	NA	0.02	301,474	FALSE			FALSE					TRUE	Maintain
71110	Radiologic examinatio	X-Ray of Ribs	April 2016	30		ACR	0.29	CMS-Other - Utilization over 25(	October 2015	XXX	0.29	0.97	NA	0.02	24,795	FALSE			FALSE					TRUE	Maintain
71111	Radiologic examinatio	X-Ray of Ribs	April 2016	30		ACR	0.32	CMS-Other - Utilization over 25(	October 2015	XXX	0.32	1.19	NA	0.02	30,595	FALSE			FALSE					TRUE	Maintain
71250	Computed tomograph	Screening CT of Thorax	October 2019	07		ACR	1.16	CMS Fastest Growing / CMS Hig	October 2008	XXX	1.08	3.04	NA	0.06	2,320,224	FALSE			FALSE					TRUE	Increase
71260	Computed tomograph	Screening CT of Thorax	October 2019	07		ACR	1.38	CMS High Expenditure Procedur	July 2015	XXX	1.16	4.07	NA	0.06	1,835,534	FALSE			FALSE					TRUE	Maintain
71270	Computed tomograph	Screening CT of Thorax	October 2019	07		ACR	1.24	CMS High Expenditure Procedur	July 2015	XXX	1.25	4.96	NA	0.06	70,977	FALSE			FALSE					TRUE	Maintain
71271	Computed tomograph	Screening CT of Thorax	October 2019	07			1.16	CMS-Other - Utilization over 30,	May 2019	XXX	1.08	3.18	NA	0.06		FALSE			FALSE					TRUE	Increase
71275	Computed tomograph	CT Angiography-Chest	January 2014	27		ACR, SIR	1.82	CMS Fastest Growing / MPC List	October 2008	XXX	1.82	6.91	NA	0.11	1,282,747	TRUE	Jun 2009	Yes	FALSE					TRUE	Decrease
72020	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.16	CMS-Other - Utilization over 10(	April 2016	XXX	0.16	0.54	NA	0.02	145,820	FALSE			FALSE					TRUE	Increase
72040	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Low Value-High Volume / CMS-(	October 2010	XXX	0.22	0.91	NA	0.02	641,468	FALSE			TRUE	The RUC recommended co	October 2011	17	Complete	TRUE	Maintain
72050	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.27	Low Value-High Volume / CMS-(	October 2010	XXX	0.27	1.25	NA	0.02	378,821	FALSE			TRUE	The RUC recommended co	October 2011	17	Complete	TRUE	Decrease
72052	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.30	Low Value-High Volume / CMS-(	October 2010	XXX	0.30	1.49	NA	0.02	80,862	FALSE			TRUE	The RUC recommended co	October 2011	17	Complete	TRUE	Decrease
72070	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.20	CMS-Other - Utilization over 25(	April 2013	XXX	0.20	0.73	NA	0.02	300,255	FALSE			FALSE					TRUE	Decrease
72072	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.23	CMS-Other - Utilization over 10(	April 2016	XXX	0.23	0.89	NA	0.02	184,802	FALSE			FALSE					TRUE	Increase
72074	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.25	CMS-Other - Utilization over 10(	October 2016	XXX	0.25	1.03	NA	0.02	12,934	FALSE			FALSE					TRUE	Increase
72080	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.21	CMS-Other - Utilization over 10(	October 2016	XXX	0.21	0.78	NA	0.02	46,745	FALSE			FALSE					TRUE	Decrease
72100	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Harvard Valued - Utilization ove	February 2010	XXX	0.22	0.92	NA	0.02	1,818,987	FALSE			TRUE	This service was brought fc	October 2010	18	Complete	TRUE	Maintain
72110	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.26	Harvard Valued - Utilization ove	October 2009	XXX	0.26	1.20	NA	0.02	821,121	FALSE			TRUE	April 2010, refer to CPT Edi	October 2010	18	Complete	TRUE	Decrease
72114	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.30	Harvard Valued - Utilization ove	February 2010	XXX	0.30	1.49	NA	0.02	96,261	FALSE			TRUE	This service was brought fc	October 2010	18	Complete	TRUE	Decrease
72120	Radiologic examinatio	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Harvard Valued - Utilization ove	February 2010	XXX	0.22	0.95	NA	0.02	52,798	FALSE			TRUE	Code 72110 was identified	October 2010	18	Complete	TRUE	Maintain
72125	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.07	CMS Fastest Growing	October 2008	XXX	1.00	3.04	NA	0.06	1,308,607	FALSE			FALSE					TRUE	Maintain
72126	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Fastest Growing	February 2009	XXX	1.22	4.06	NA	0.06	20,553	FALSE			FALSE					TRUE	Maintain
72127	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Fastest Growing	February 2009	XXX	1.27	4.94	NA	0.06	1,798	FALSE			FALSE					TRUE	Maintain
72128	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.00	CMS Fastest Growing	October 2008	XXX	1.00	3.03	NA	0.06	199,533	FALSE			FALSE					TRUE	Maintain
72129	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Fastest Growing	February 2009	XXX	1.22	4.09	NA	0.06	26,437	FALSE			FALSE					TRUE	Maintain
72130	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Fastest Growing	February 2009	XXX	1.27	4.97	NA	0.06	1,318	FALSE			FALSE					TRUE	Maintain
72131	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.00	CMS Fastest Growing / CMS-Otl	February 2009	XXX	1.00	3.02	NA	0.06	519,043	FALSE			FALSE					TRUE	Maintain
72132	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Fastest Growing / CMS-Otl	February 2009	XXX	1.22	4.06	NA	0.06	61,654	FALSE			FALSE					TRUE	Maintain
72133	Computed tomograph	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Fastest Growing / CMS-Otl	February 2009	XXX	1.27	4.94	NA	0.06	4,078	FALSE			FALSE					TRUE	Maintain
72141	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25		ACR	1.48	CMS High Expenditure Procedur	September 2011	XXX	1.48	4.63	NA	0.07	600,156	FALSE			FALSE					TRUE	Decrease
72142	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25		ACR	1.78	CMS High Expenditure Procedur	April 2013	XXX	1.78	7.12	NA	0.11	3,391	FALSE			FALSE					TRUE	Decrease
72146	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25		ACR	1.48	CMS High Expenditure Procedur	April 2013	XXX	1.48	4.63	NA	0.07	223,500	FALSE			FALSE					TRUE	Decrease
72147	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25		ACR	1.78	CMS High Expenditure Procedur	April 2013	XXX	1.78	7.06	NA	0.11	3,124	FALSE			FALSE					TRUE	Decrease
72148	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25		AAOS, AUI	1.48	CMS-Other - Utilization over 50(	April 2011	XXX	1.48	4.64	NA	0.07	1,346,832	FALSE			FALSE					TRUE	Maintain
72149	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25			1.78	CMS High Expenditure Procedur	April 2013	XXX	1.78	6.98	NA	0.11	5,622	FALSE			FALSE					TRUE	Maintain
72156	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25			2.29	CMS High Expenditure Procedur	April 2013	XXX	2.29	8.07	NA	0.13	120,879	FALSE			FALSE					TRUE	Decrease
72157	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25			2.29	CMS High Expenditure Procedur	April 2013	XXX	2.29	8.09	NA	0.13	98,889	FALSE			FALSE					TRUE	Decrease
72158	Magnetic resonance (	MRI Neck and Lumbar S	April 2013	25			2.29	CMS High Expenditure Procedur	April 2013	XXX	2.29	8.05	NA	0.13	244,364	FALSE			FALSE					TRUE	Decrease
72170	Radiologic examinatio	X-Ray Exam – Pelvis	January 2019	28		AAOS, ACF	0.17	Low Value-High Volume / Codes	October 2010	XXX	0.17	0.62	NA	0.02	792,294	FALSE			TRUE	The Joint Workgroup recor	October 2014	27	Complete	TRUE	Maintain
72190	Radiologic examinatio	X-Ray Exam – Pelvis	January 2019	28		AAOS, ACF	0.25	CMS-Other - Utilization over 30,	October 2017	XXX	0.25	0.95	NA	0.02	56,338	FALSE			FALSE					TRUE	Increase
72191	Computed tomograph	CT Angiography	October 2013	12		ACR, SIR	1.81	High Volume Growth1 / CMS Fa	February 2008	XXX	1.81	7.69	NA	0.11	2,441	FALSE			TRUE	The Workgroup accepts th	October 2010	19	Complete	TRUE	Maintain
72192	Computed tomograph	CT Pelvis	October 2008	26		ACR	1.09	Codes Reported Together 95% c	October 2008	XXX	1.09	3.04	NA	0.06	183,953	FALSE			TRUE	The specialty society indica	October 2009	37	Complete	TRUE	Maintain
72193	Computed tomograph	CT Pelvis	October 2008	26		ACR	1.16	Codes Reported Together 95% c	October 2008	XXX	1.16	6.05	NA	0.06	37,206	FALSE			TRUE	The specialty society indica	October 2009	37	Complete	TRUE	Maintain
72194	Computed tomograph	CT Abdomen and Pelvis	April 2014	44		ACR	1.22	Codes Reported Together 95% c	February 2008	XXX	1.22	6.81	NA	0.07	5,552	FALSE			TRUE	Referred to the CPT Editori	October 2009	37	Complete	TRUE	Maintain
72195	Magnetic resonance (	MRI Pelvis	October 2016	21	RUC	ACR	1.46	CMS High Expenditure Procedur	July 2015	XXX	1.46	6.02	NA	0.08	85,947	FALSE			FALSE					TRUE	Maintain
72196	Magnetic resonance (	MRI Pelvis	October 2016	21	RUC	ACR	1.73	CMS High Expenditure Procedur	July 2015	XXX	1.73	7.04	NA	0.11	2,606	FALSE			FALSE					TRUE	Maintain
72197	Magnetic resonance (	MRI Pelvis	October 2016	21	RUC	ACR	2.20	CMS High Expenditure Procedur	July 2015	XXX	2.20	8.83	NA	0.12	214,192	FALSE			FALSE					TRUE	Decrease
72200	Radiologic examinatio	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.20	CMS-Other - Utilization over 10(	October 2016	XXX	0.17	0.77	NA	0.02	14,605	FALSE			FALSE					TRUE	Increase
72202	Radiologic examinatio	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.26	CMS-Other - Utilization over 10(	October 2016	XXX	0.23	0.89	NA	0.02	39,418	FALSE			FALSE					TRUE	Increase
72220	Radiologic examinatio	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.20	CMS-Other - Utilization over 10(	April 2016	XXX	0.17	0.75	NA	0.02	116,528	FALSE			FALSE					TRUE	Increase
72240	Myelography, cervical	Myelography	April 2014	17		ACR, ASNF	0.91	Codes Reported Together 75% c	October 2012	XXX	0.91	2.43	NA	0.06	647	FALSE			TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Maintain
72255	Myelography, thoracic	Myelography	April 2014	17		ACR, ASNF	0.91	Codes Reported Together 75% c	October 2013	XXX	0.91	2.43	NA	0.11	125	FALSE			TRUE	This code change applicatio	October 2013	21	Complete	TRUE	Maintain
72265	Myelography, lumbosa	Myelography	April 2014	17		ACR, ASNF	0.83	Codes Reported Together 75% c	October 2012	XXX	0.83	2.29	NA	0.05	3,681	FALSE			TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Maintain
72270	Myelography, 2 or mo	Myelography	April 2014	17		ACR, ASNF	1.33	Codes Reported Together 75% c	October 2012	XXX	1.33	2.94	NA	0.07	1,087	FALSE			TRUE	Joint Workgroup requests t	October 2013	21	Complete	TRUE	Maintain
72275	Epidurography, radiol	Epidurography	January 2020	37		ASA, AAPN	Deleted from CPT	Different Performing Specialty f	October 2009	XXX	0.76	3.29	NA	0.05	66,516	TRUE	Oct 2009 a	Yes	TRUE	In October 2019, this servic	October 2020	40	complete	TRUE	Deleted from CPT
72291	Radiological supervisi	Percutaneous Vertebro	April 2014	06			Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	Joint Workgroup recomme	February 2014	16	Complete	TRUE	Deleted from CPT
72292	Radiological supervisi	Percutaneous Vertebro	April 2014	06			Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	Joint Workgroup recomme	February 2014	16	Complete	TRUE	Deleted from CPT
73000	Radiologic examinatio	X-Ray – Clavicle/Should	October 2018	17		ACR, AAOS	0.16	CMS-Other - Utilization over 30,	October 2017	XXX	0.16	0.76	NA	0.02	100,682	FALSE			FALSE					TRUE	Maintain
73010	Radiologic examinatio	X-Ray – Clavicle/Should	October 2018	17		ACR, AAOS	0.17	CMS-Other - Utilization over 30,	October 2017	XXX	0.17	0.50	NA	0.02	51,052	FALSE			FALSE					TRUE	Maintain
73020	Radiologic examinatio	X-Ray – Clavicle/Should	October 2018	17		ACR, AAOS	0.15	CMS-Other - Utilization over 30,	October 2017	XXX	0.15	0.46	NA	0.02	119,144	FALSE			FALSE					TRUE	Maintain
73030	Radiologic examinatio	X-Ray – Clavicle/Should	October 2018	17		ACR, AAOS	0.18	Low Value-High Volume / CMS-(	October 2010	XXX	0.18	0.80	NA	0.02	2,765,924	FALSE			FALSE					TRUE	Maintain
73050	Radiologic examinatio	X-Ray – Clavicle/Should	October 2018	17		ACR, AAOS	0.18	CMS-Other - Utilization over 30,	October 2017	XXX	0.18	0.63	NA	0.02	8,123	FALSE			FALSE					TRUE	Decrease
73060	Radiologic examinatio	X-Ray Exams	September 2014	17		AAOS, ACF	0.16	CMS-Other - Utilization over 25(	April 2013	XXX	0.16	0.76	NA	0.02	341,436	FALSE			FALSE					TRUE	Decrease
73070	Radiologic examinatio	X-Ray Elbow/Forearm	January 2019	30		AAOS, ACF	0.16	CMS-Other - Utilization over 10(	April 2016	XXX	0.16	0.67	NA	0.02	219,794	FALSE			FALSE					TRUE	Increase
73080	Radiologic examinatio	X-Ray Elbow/Forearm	January 2019	30		AAOS, ACF	0.17	Harvard Valued - Utilization ove	October 2009	XXX	0.17	0.75	NA	0.02	404,093	FALSE			FALSE					TRUE	Maintain
73090	Radiologic examinatio	X-Ray Elbow/Forearm	January 2019	30		AAOS, ACF	0.16	CMS-Other - Utilization over 10(	April 2016	XXX	0.16	0.67	NA	0.02	230,897	FALSE			FALSE					TRUE	Maintain
73100	Radiologic examinatio	X-Ray Wrist	April 2016	32		ACR	0.16	CMS High Expenditure Procedur	July 2015	XXX	0.16	0.81	NA	0.02	274,134	FALSE			FALSE					TRUE	Maintain
73110	Radiologic examinatio	X-Ray Wrist	April 2016	32		ACR	0.17	Low Value-High Volume / CMS I	October 2010	XXX	0.17	0.99	NA	0.02	1,064,258	FALSE			FALSE					TRUE	Maintain
73120	Radiologic examinatio	X-Ray of Hand/Fingers	April 2016	33		ACR	0.16	CMS High Expenditure Procedur	July 2015	XXX	0.16	0.73	NA	0.02	278,753	FALSE			FALSE					TRUE	Maintain
73130	Radiologic examinatio	X-Ray of Hand/Fingers	April 2016	33		ACR	0.17	Low Value-High Volume / CMS I	October 2010	XXX	0.17	0.87	NA	0.02	1,282,863	FALSE			FALSE					TRUE	Maintain
73140	Radiologic examinatio	X-Ray of Hand/Fingers	April 2016	33		ACR	0.13	CMS High Expenditure Procedur	July 2015	XXX	0.13	0.94	NA	0.02	388,288	FALSE			FALSE					TRUE	Maintain
73200	Computed tomograph	CT Upper Extremity	October 2009	23		ACR	1.09	CMS Fastest Growing	October 2008	XXX	1.00	4.14	NA	0.06	126,320	FALSE			FALSE					TRUE	Maintain
73201	Computed tomograph	CT Upper Extremity	October 2009	40		ACR	Remove from screen	CMS Fastest Growing	February 2009	XXX	1.16	5.25	NA	0.06	21,360	FALSE			FALSE					TRUE	Remove from Screen
73202	Computed tomograph	CT Upper Extremity	October 2009	40		ACR	Remove from screen	CMS Fastest Growing	February 2009	XXX	1.22	6.80	NA	0.07	1,982	FALSE			FALSE					TRUE	Remove from Screen
73206	Computed tomograph	CT Angiography	October 2013	12		ACR, SIR	Survey with all CTA codes for	CMS Request - Final Rule for 20	May 2013	XXX	1.81	7.60	NA	0.13	6,543	FALSE			FALSE					TRUE	Remove from Screen
73218	Magnetic resonance (	MRI	October 2013	18		ACR	CPT Assistant published.	CMS Fastest Growing	October 2008	XXX	1.35	8.72	NA	0.07	33,624	TRUE	Feb 2011	Yes	FALSE					TRUE	Maintain
73221	Magnetic resonance (	MRI	January 2012	20		ACR	1.35	CMS Fastest Growing / CMS Hig	October 2008	XXX	1.35	5.13	NA	0.08	475,051	FALSE			FALSE					TRUE	Maintain
73500	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	Deleted from CPT	CMS-Other - Utilization over 50(	April 2011							FALSE			TRUE	In Jan 2012, the specialty s	October 2014	27	Complete	TRUE	Deleted from CPT
73501	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.17	Codes Reported Together 75% c	October 2014	XXX	0.18	0.74	NA	0.02	285,022	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73502	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.22	Codes Reported Together 75% c	October 2014	XXX	0.22	1.12	NA	0.02	2,694,536	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73503	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.27	Codes Reported Together 75% c	October 2014	XXX	0.27	1.42	NA	0.02	46,804	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73510	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	Deleted from CPT	Havard Valued - Utilization over	October 2008							FALSE			FALSE		October 2014	27	Complete	TRUE	Deleted from CPT
73520	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	Deleted from CPT	CMS-Other - Utilization over 25(	April 2013							FALSE			TRUE	CPT code 73520 was identi	October 2014	27	Complete	TRUE	Deleted from CPT
73521	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.22	Codes Reported Together 75% c	October 2014	XXX	0.22	0.96	NA	0.02	158,149	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73522	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.29	Codes Reported Together 75% c	October 2014	XXX	0.29	1.25	NA	0.02	188,143	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73523	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.31	Codes Reported Together 75% c	October 2014	XXX	0.31	1.46	NA	0.02	107,476	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease
73540	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	Deleted from CPT	Codes Reported Together 75% c	October 2014							FALSE			FALSE		October 2014	27	Complete	TRUE	Deleted from CPT
73542	Radiological examinat	Sacroiliac Joint Arthrogr	April 2010	45		ASA, AAPN	Deleted from CPT	Different Performing Specialty f	October 2009							TRUE	Deleted fr	Yes	TRUE	The RUC recommends refe	February 2011	76	Code Dele	TRUE	Deleted from CPT
73550	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	Deleted from CPT	CMS-Other - Utilization over 50(	April 2011							FALSE			TRUE	In Jan 2012, the specialty s	October 2014	27	Complete	TRUE	Deleted from CPT
73551	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14		AAOS, ACF	0.16	Codes Reported Together 75% c	October 2014	XXX	0.16	0.68	NA	0.02	37,871	FALSE			FALSE		October 2014	27	Complete	TRUE	Decrease

73552	Radiologic examinatio	Radiologic Exam-Hip an	April 2015	14			AAOS, ACF	0.18	Codes Reported Together 75% c	October 2014	XXX	0.18	0.83	NA	0.02	548,327	FALSE		FALSE		October 2014	27	Complete	TRUE	Decrease
73560	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.16	Low Value-High Volume	October 2010	XXX	0.16	0.82	NA	0.02	1,784,814	FALSE		FALSE					TRUE	Decrease
73562	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.18	Low Value-High Volume	October 2010	XXX	0.18	0.98	NA	0.02	2,516,006	FALSE		FALSE					TRUE	Maintain
73564	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.22	Low Value-High Volume	October 2010	XXX	0.22	1.10	NA	0.02	1,648,754	FALSE		FALSE					TRUE	Maintain
73565	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.16	CMS-Other - Utilization over 25(	April 2013	XXX	0.16	1.01	NA	0.02	207,121	FALSE		FALSE					TRUE	Decrease
73580	Radiologic examinatio	Contrast X-Ray of Knee	October 2020	23	October 2021	RUC	AAOS	Survey and review CPT Assist	High Volume Growth1 / CMS Fa	February 2008	XXX	0.54	3.68	NA	0.06	30,453	TRUE	Jun 2012 Yes	FALSE					FALSE	Maintain
73590	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.16	CMS-Other - Utilization over 25(	April 2013	XXX	0.16	0.74	NA	0.02	500,593	FALSE		FALSE					TRUE	Decrease
73600	Radiologic examinatio	X-Ray Exams	September 2014	17			AAOS, ACF	0.16	CMS-Other - Utilization over 25(	April 2013	XXX	0.16	0.77	NA	0.02	240,693	FALSE		FALSE					TRUE	Maintain
73610	Radiologic examinatio	Radiologic Examination	October 2009	24			ACR, AAO	0.17	Havard Valued - Utilization over	October 2008	XXX	0.17	0.88	NA	0.02	1,281,503	FALSE		FALSE					TRUE	Maintain
73620	Radiologic examinatio	X-Ray Exam of Foot	April 2011	27			ACR, AAO	0.16	Low Value-High Volume	October 2010	XXX	0.16	0.65	NA	0.02	574,129	FALSE		FALSE					TRUE	Maintain
73630	Radiologic examinatio	Radiologic Examination	October 2009	24			ACR, AAO	0.17	Havard Valued - Utilization over	October 2008	XXX	0.17	0.81	NA	0.02	2,820,181	FALSE		FALSE					TRUE	Maintain
73650	Radiologic examinatio	X-Ray Heel	January 2019	31			AAOS, ACF	0.16	CMS-Other - Utilization over 10(	April 2016	XXX	0.16	0.66	NA	0.02	81,836	FALSE		FALSE					TRUE	Maintain
73660	Radiologic examinatio	X-Ray Toe	January 2019	32			AAOS, ACF	0.13	CMS-Other - Utilization over 10(	April 2016	XXX	0.13	0.70	NA	0.02	120,091	FALSE		FALSE					TRUE	Maintain
73700	Computed tomograph	CT Lower Extremity	April 2018	21			ACR	1.00	CMS Fastest Growing	October 2008	XXX	1.00	3.02	NA	0.06	338,278	FALSE		FALSE					TRUE	Maintain
73701	Computed tomograph	CT Lower Extremity	April 2018	21			ACR	1.16	High Volume Growth1 / CMS-Ot	February 2009	XXX	1.16	4.06	NA	0.06	47,637	FALSE		FALSE					TRUE	Maintain
73702	Computed tomograph	CT Lower Extremity	April 2018	21			ACR	1.22	High Volume Growth1	February 2009	XXX	1.22	4.88	NA	0.06	4,842	FALSE		FALSE					TRUE	Maintain
73706	Computed tomograph	CT Angiography	October 2013	12			ACR, SIR	Survey for October 2013. Rer	High Volume Growth1	February 2008	XXX	1.90	8.30	NA	0.13	16,508	FALSE		FALSE					TRUE	Remove from Screen
73718	Magnetic resonance (r	MRI Lower Extremity	October 2016	20		RUC	ACR	1.35	CMS High Expenditure Procedur	July 2015	XXX	1.35	5.93	NA	0.07	148,143	FALSE		FALSE					TRUE	Maintain
73719	Magnetic resonance (r	MRI Lower Extremity	October 2016	20		RUC	ACR	1.62	CMS High Expenditure Procedur	July 2015	XXX	1.62	6.94	NA	0.11	1,344	FALSE		FALSE					TRUE	Maintain
73720	Magnetic resonance (r	MRI Lower Extremity	October 2016	20		RUC	ACR	2.15	CMS High Expenditure Procedur	July 2015	XXX	2.15	8.88	NA	0.12	64,864	FALSE		FALSE					TRUE	Maintain
73721	Magnetic resonance (r	MRI of Lower Extremity	January 2012	20			ACR	1.35	MPC List	October 2010	XXX	1.35	5.11	NA	0.08	670,662	FALSE		FALSE					TRUE	Maintain
74000	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	Deleted from CPT	Low Value-High Volume / CMS I	October 2010							FALSE		FALSE		February 2016	21	Complete	TRUE	Deleted from CPT
74010	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE		FALSE		February 2016	21	Complete	TRUE	Deleted from CPT
74018	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	0.18	CMS High Expenditure Procedur	February 2016	XXX	0.18	0.67	NA	0.02	2,153,087	FALSE		FALSE		February 2016	21	Complete	TRUE	Decrease
74019	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	0.23	CMS High Expenditure Procedur	February 2016	XXX	0.23	0.83	NA	0.02	429,437	FALSE		FALSE		February 2016	21	Complete	TRUE	Decrease
74020	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	Deleted from CPT	CMS High Expenditure Procedur	July 2015							FALSE		FALSE		February 2016	21	Complete	TRUE	Deleted from CPT
74021	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	0.27	CMS High Expenditure Procedur	February 2016	XXX	0.27	0.96	NA	0.02	58,811	FALSE		FALSE		February 2016	21	Complete	TRUE	Decrease
74022	Radiologic examinatio	Abdominal X-Ray	April 2016	08			ACR	0.32	CMS High Expenditure Procedur	July 2015	XXX	0.32	1.11	NA	0.02	283,318	FALSE		FALSE		February 2016	21	Complete	TRUE	Maintain
74150	Computed tomograph	CT Abdomen	February 2008	S			ACR	Review PE. 0.35	Codes Reported Together 95% c	February 2008	XXX	1.19	3.05	NA	0.06	77,343	FALSE		TRUE	Referred to the CPT Editori	October 2009	37	Complete	TRUE	Maintain
74160	Computed tomograph	CT Abdomen and Pelvis	April 2014	44			ACR	0.42	Codes Reported Together 95% c	February 2008	XXX	1.27	6.07	NA	0.06	105,409	FALSE		TRUE	Referred to the CPT Editori	October 2009	37	Complete	TRUE	Maintain
74170	Computed tomograph	CT Abdomen	April 2012	34			ACR	1.40	Codes Reported Together 95% c	February 2008	XXX	1.40	6.85	NA	0.08	107,476	FALSE		TRUE	Referred to the CPT Editori	October 2009	37	Complete	TRUE	Maintain
74174	Computed tomograph	CT Angiography	October 2013	12			ACR, SIR	2.20	Codes Reported Together 75% or More-Part1 / CMS		XXX	2.20	9.64	NA	0.15	294,980	FALSE		FALSE					TRUE	Decrease
74175	Computed tomograph	CT Angiography	October 2013	12			ACR, SIR	1.82	CMS Fastest Growing / Codes R	October 2008	XXX	1.82	7.68	NA	0.11	37,638	FALSE		TRUE	The ACR submitted a letter	October 2010	19	Complete	TRUE	Decrease
74176	Computed tomograph	CT Abdomen/CT Pelvis	February 2010	16			ACR	1.74	CMS Fastest Growing	October 2009	XXX	1.74	3.91	NA	0.10	2,284,436	FALSE		FALSE		October 2009	37		TRUE	Decrease
74177	Computed tomograph	CT Abdomen and Pelvis	April 2014	44			ACR	1.82	CMS Fastest Growing / CMS Rec	October 2009	XXX	1.82	7.79	NA	0.11	3,361,910	FALSE		FALSE		October 2009	37		TRUE	Decrease
74178	Computed tomograph	CT Abdomen/CT Pelvis	February 2010	16			ACR	2.01	CMS Fastest Growing	October 2009	XXX	2.01	8.78	NA	0.11	534,971	FALSE		FALSE		October 2009	37		TRUE	Decrease
74181	Magnetic resonance (r	MRI of Abdomen	October 2016	21		RUC	ACR	1.46	CMS High Expenditure Procedur	July 2015	XXX	1.46	4.86	NA	0.07	117,420	FALSE		FALSE					TRUE	Maintain
74182	Magnetic resonance (r	MRI of Abdomen	October 2016	21		RUC	ACR	1.73	CMS High Expenditure Procedur	July 2015	XXX	1.73	8.19	NA	0.11	4,286	FALSE		FALSE					TRUE	Maintain
74183	Magnetic resonance (r	MRI of Abdomen	October 2016	21		RUC	ACR	2.20	CMS High Expenditure Procedur	July 2015	XXX	2.20	8.85	NA	0.12	354,840	FALSE		FALSE					TRUE	Decrease
74210	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	0.59	CMS-Other - Utilization over 10(	October 2016	XXX	0.59	2.27	NA	0.05	1,577	FALSE		FALSE					TRUE	Maintain
74220	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	0.60	CMS-Other - Utilization over 10(	April 2016	XXX	0.60	2.31	NA	0.05	196,573	FALSE		FALSE					TRUE	Decrease
74221	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12				0.70	CMS-Other - Utilization over 30,	October 2018	XXX	0.70	2.57	NA	0.05		FALSE		FALSE					TRUE	Increase
74230	Radiologic examinatio	X-Ray Esophagus	April 2017	25			ACR	0.53	CMS-Other - Utilization over 25(	April 2013	XXX	0.53	3.33	NA	0.05	370,056	FALSE		FALSE					TRUE	Maintain
74240	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	0.80	CMS-Other - Utilization over 30,	October 2017	XXX	0.80	2.82	NA	0.05	53,309	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74241	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	Deleted from CPT	CMS-Other - Utilization over 30,	October 2017						25,415	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Deleted from CPT
74245	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	Deleted from CPT	CMS-Other - Utilization over 30,	October 2017						12,946	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Deleted from CPT
74246	Radiologic examinatio	X-Ray Exam – Upper GI	January 2019	12			ACR	0.90	CMS-Other - Utilization over 30,	October 2017	XXX	0.90	3.26	NA	0.05	34,438	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74247	Radiological examinat	X-Ray Exam – Upper GI	January 2019	12			ACR	Deleted from CPT	Harvard Valued - Utilization ove	April 2011						21,591	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Deleted from CPT
74248	Radiologic small intes	X-Ray Exam – Upper GI	January 2019	12				0.70	CMS-Other - Utilization over 30,	October 2018	ZZZ	0.70	1.75	NA	0.04		FALSE		TRUE	In January 2019, the RUC d	February 2019-EC	EC-T Is	complete	TRUE	Increase
74249	Radiological examinat	X-Ray Exam – Upper GI	January 2019	12			ACR	Deleted from CPT	CMS-Other - Utilization over 30,	October 2017						13,972	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Deleted from CPT
74250	Radiologic examinatio	Lower Gastrointestinal	October 2018	11			ACR	0.81	CMS-Other - Utilization over 30,	October 2017	XXX	0.81	2.82	NA	0.05	52,021	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74251	Radiologic examinatio	Lower Gastrointestinal	October 2018	11			ACR	1.17	CMS-Other - Utilization over 30,	October 2017	XXX	1.17	10.69	NA	0.06	206	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74260	Duodenography, hypo	X-Ray Exam – Small Inte	October 2018	11			ACR	Deleted from CPT	CMS-Other - Utilization over 30,	October 2017						24	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Deleted from CPT
74270	Radiologic examinatio	Lower Gastrointestinal	October 2018	11			ACR	1.04	CMS-Other - Utilization over 30,	October 2017	XXX	1.04	3.56	NA	0.06	28,934	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74280	Radiologic examinatio	Lower Gastrointestinal	October 2018	11			ACR	1.26	Harvard Valued - Utilization ove	April 2011	XXX	1.26	5.41	NA	0.06	8,205	FALSE		TRUE	In January 2018, the RUC re	May 2018	27	Yes	TRUE	Increase
74300	Cholangiography and/	X-Rays at Surgery Add-(	April 2019	19			ACR, SAGE	0.32	CMS-Other - Utilization over 30,	October 2018	XXX	0.00	0.00	NA	0.00	29,648	FALSE		FALSE					TRUE	Decrease
74301	Cholangiography and/	X-Rays at Surgery Add-(	October 2020	19			ACR, ACS,	0.21	CMS-Other - Utilization over 30,	October 2018	ZZZ	0.00	0.00	NA	0.00	63	FALSE		FALSE					TRUE	Maintain
74305	Deleted from CPT	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE		TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
74320	Cholangiography, per	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE		TRUE	The Joint Workgroup recor	February 2015	16	Complete	TRUE	Deleted from CPT
74327	Postoperative biliary c	Percutaneous Biliary Pr	October 2015	06		RUC	ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	February 2015							FALSE		FALSE		February 2015	16		TRUE	Deleted from CPT
74328	Endoscopic catheteriz	X-Rays at Surgery Add-(	April 2019	19			ACR, SAGE	0.47	CMS-Other - Utilization over 30,	October 2018	XXX	0.00	0.00	NA	0.00	64,506	FALSE		FALSE					TRUE	Decrease
74329	Endoscopic catheteriz	X-Rays at Surgery Add-(	April 2019	19			ACR, SAGE	0.50	CMS-Other - Utilization over 30,	October 2018	XXX	0.00	0.00	NA	0.00	2,990	FALSE		FALSE					TRUE	Decrease
74330	Combined endoscopic	X-Rays at Surgery Add-(	April 2019	19			ACR, SAGE	0.70	CMS-Other - Utilization over 30,	October 2018	XXX	0.00	0.00	NA	0.00	13,859	FALSE		FALSE					TRUE	Decrease
74400	Urography (pyelograp	Contrast X-Ray Exams	September 2011	31			ACR	0.49	Harvard Valued - Utilization ove	April 2011	XXX	0.49	3.46	NA	0.03	5,180	FALSE		FALSE					TRUE	Maintain
74420	Urography, retrograde	X-Ray Urinary Tract	April 2017	26			ACR, AUA	0.52	CMS-Other - Utilization over 10(	April 2016	XXX	0.52	1.69	NA	0.03	166,220	FALSE		FALSE					TRUE	Increase
74425	Urography, antegrade	Urography	October 2018	18			ACR, AUA,	0.51, editorially revised	Codes Reported Together 75% c	October 2012	XXX	0.51	3.53	NA	0.03	3,703	FALSE		TRUE	CPT code 74425 was bundl	September 2019	27	yes	TRUE	Increase
74475	Introduction of intrac	Genitourinary Catheter	January 2015	09			ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE		TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
74480	Introduction of ureter	Genitourinary Catheter	January 2015	09			ACR, SIR	Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE		TRUE	The Joint Workgroup recor	October 2014	18	Complete	TRUE	Deleted from CPT
74485	Dilation of ureter(s) o	Dilation of Urinary Trac	January 2018	12				0.83	Codes Reported Together 75% c	September 2017	XXX	0.83	2.63	NA	0.03	1,628	FALSE		FALSE					TRUE	Increase
75561	Cardiac magnetic resonance imaging for morp		January 2021	29				Maintain	High Volume Growth7	October 2020	XXX	2.60	9.39	NA	0.13	29,956	FALSE		FALSE					TRUE	Remove from screen
75572	Computed tomography, heart, with contrast n		January 2021	29				Maintain	High Volume Growth7	October 2020	XXX	1.75	6.13	NA	0.08	29,288	FALSE		FALSE					TRUE	Remove from screen
75574	Computed tomographic angiography, heart, c		January 2021	29			ACR, SIR, A	Maintain	CMS Request - Final Rule for 20	May 2013	XXX	2.40	9.10	NA	0.14	86,531	FALSE		FALSE					TRUE	Remove from screen
75625	Aortography, abdomir	Abdominal Aortography	October 2018	19			ACC, SCAI,	1.75	CMS-Other - Utilization over 30,	October 2017	XXX	1.44	2.29	NA	0.20	96,916	FALSE		FALSE					TRUE	Increase
75630	Aortography, abdomir	Abdominal Aortography	October 2018	19			ACC, SCAI,	2.00	CMS-Other - Utilization over 30,	October 2017	XXX	2.00	2.62	NA	0.22	27,465	FALSE		FALSE					TRUE	Increase
75635	Computed tomograph	CT Angiography of Abdo	April 2016	34			ACR	2.40	High Volume Growth1 / CMS Hi	February 2008	XXX	2.40	10.42	NA	0.17	114,472	FALSE		FALSE					TRUE	Maintain
75650	Angiography, carotid,	Carotid Angiography	April 2010	45			ACC, ACR,	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup recommen	February 2012	12	Complete	TRUE	Deleted from CPT
75671	Angiography, carotid,	Carotid Angiography	April 2010	45			AANS/CNS	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup recommen	February 2012	12	Complete	TRUE	Deleted from CPT
75680	Angiography, carotid,	Carotid Angiography	April 2010	45			AANS/CNS	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup recommen	February 2012	12	Complete	TRUE	Deleted from CPT
75710	Angiography, extremit	Angiography of Extremi	January 2021	29	January 2024	RAW	ACR, ACC,	Refer to CPT Assistant and re	CMS High Expenditure Procedur	July 2015	XXX	1.75	2.66	NA	0.23	157,614	TRUE	July 2021	FALSE					FALSE	Increase
75716	Angiography, extremit	Angiography of Extremi	October 2016	22		RUC	ACR, ACC,	1.97	CMS High Expenditure Procedur	July 2015	XXX	1.97	2.79	NA	0.23	74,926	FALSE		FALSE					TRUE	Increase
75722	Angiography, renal, ur	Renal Angiography	April 2010	45			ACC, ACR,	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup recommen	February 2011	06	Code Dele	TRUE	Deleted from CPT
75724	Angiography, renal, bi	Renal Angiography	April 2010	45			ACC, ACR,	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup recommen	February 2011	06	Code Dele	TRUE	Deleted from CPT
75726	Angiography, visceral,	Angiography	October 2018	20			SCAI, SIR,	2.05	CMS-Other - Utilization over 30,	October 2017	XXX	2.05	3.00	NA	0.15	41,396	FALSE		FALSE					TRUE	Increase
75774	Angiography, selective	Angiography	October 2018	20			SCAI, SIR,	1.01	CMS-Other - Utilization over 30,	October 2017	ZZZ	1.01	1.93	NA	0.10	77,363	FALSE		FALSE					TRUE	Increase
75790	Deleted from CPT	Arteriovenous Shunt Im	April 2009	9			SVS, SIR, A	Deleted from CPT	Codes Reported Together 95% c	February 2008							FALSE		TRUE	Referred to the CPT Editori	February 2009	31	Deleted	TRUE	Deleted from CPT
75791	Angiography, arteriov	Dialysis Circuit -1	January 2016	14			ACR, RPA,	Deleted from CPT	Codes Reported Together 95% or More								FALSE		FALSE		October 2015	24	Complete	TRUE	Deleted from CPT
75820	Venography, extremit	Venography	January 2020	29				1.05	CMS-Other - Utilization over 20,	January 2019	XXX	1.05	2.30	NA	0.10	23,689	FALSE		FALSE					TRUE	Increase
75822	Venography, extremit	Venography	January 2020	29				1.48	CMS-Other - Utilization over 20,	October 2019	XXX	1.48	2.51	NA	0.14	10,692	FALSE		FALSE					TRUE	Increase
75885	Percutaneous transhe	Interventional Radiolog	February 2009	21			ACR, SIR	New PE inputs	CMS Request - Practice Expense	NA	XXX	1.44	2.64	NA	0.10	348	FALSE		FALSE					TRUE	PE Only
75887	Percutaneous transhe	Interventional Radiolog	February 2009	21			ACR, SIR	New PE inputs	CMS Request - Practice Expense	NA	XXX	1.44	2.68	NA	0.10	525	FALSE		FALSE					TRUE	PE Only
75894	Transcatheter therapy	Transcatheter Procedur	January 2021	29			ACC, ACR,	Maintain	Codes Reported Together 75% c	February 2010	XXX	0.00	0.00	NA	0.00	9,539	FALSE		FALSE		The Workgroup accepts th	RAW will assess Oct 2018			TRUE	Maintain
75896	Transcatheter therapy	Intracranial Endovascul	April 2015	09			AANS/CNS	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	AANS indicated that they v	February 2014 Febi	21 & 14	Complete	TRUE	Deleted from CPT
75898	Angiography through	Intracranial Endovascul	January 2019	37			AANS/CNS	Refer to CPT Assistant	Codes Reported Together 75% c	February 2010	XXX	0.00	0.00	NA	0.00	11,637	TRUE	Septembe complete	TRUE	The Workgroup accepts th	February 2014 Febi	21	Complete	TRUE	Contractor Price
75940	Percutaneous placem	Major Vein Revision	April 2010	45			ACR, SIR, S	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE		TRUE	The Workgroup accepts th	February 2011	14	Code Dele	TRUE	Deleted from CPT
75945	Intravascular ultrasou	Intravascular Ultrasoun	January 2015	07			ACC,SCAI,	Deleted from CPT	Final Rule for 2015	July 2014							FALSE		TRUE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Deleted from CPT
75946	Intravascular ultrasou	Intravascular Ultrasoun	January 2015	07			ACC,SCAI,	Deleted from CPT	Final Rule for 2015	July 2014							FALSE		TRUE	A CCP was submitted for th	October 2014	13	Complete	TRUE	Deleted from CPT
75952	Endovascular repair o	Endovascular Repair Pr	January 2017	10			SVS, SIR, S	Deleted from CPT	Codes Reported Together 75%o	October 2015							FALSE		FALSE					TRUE	Deleted from CPT

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77262	Therapeutic radiology	Radiation Therapy Plan	April 2016	37			ASTRO	2.00	CMS High Expenditure Procedur	July 2015	XXX	2.00	0.99	0.99	0.14	3,526	FALSE			FALSE							TRUE	Decrease
77263	Therapeutic radiology	Radiation Therapy Plan	April 2016	37			ASTRO	3.14	CMS High Expenditure Procedur	July 2015	XXX	3.14	1.51	1.51	0.22	297,484	FALSE			FALSE							TRUE	Maintain
77280	Therapeutic radiology	Set Radiation Therapy F	January 2013	14			ASTRO	0.70	Harvard Valued - Utilization ove	April 2011	XXX	0.70	7.55	NA	0.05	370,105	FALSE			TRUE	ASTRO reviewed the proce	October 2012	22	Complete	TRUE	Maintain
77285	Therapeutic radiology	Respiratory Motion Ma	January 2013	14			ASTRO	1.05	Harvard Valued - Utilization ove	September 2011	XXX	1.05	12.64	NA	0.06	4,612	FALSE			TRUE	ASTRO reviewed the proce	October 2012	22	Complete	TRUE	Maintain
77290	Therapeutic radiology	Respiratory Motion Ma	January 2013	14			ASTRO	1.56	MPC List / Harvard Valued - Util	October 2010	XXX	1.56	12.74	NA	0.07	210,211	FALSE			TRUE	ASTRO reviewed the proce	October 2012	22	Complete	TRUE	Maintain
77293	Respiratory motion m	Respiratory Motion Ma	January 2013	14			ASTRO	2.00	Harvard Valued - Utilization over	30,000	ZZZ	2.00	10.91	NA	0.13	31,536	FALSE			FALSE		October 2012	22	Complete	TRUE	Decrease
77295	3-dimensional radioth	Surface Radionuclide Hi	January 2013	14			ASTRO	4.29	Harvard Valued - Utilization ove	September 2011	XXX	4.29	9.58	NA	0.20	142,124	FALSE			TRUE	ASTRO reviewed the proce	October 2012, Octo	22, 28/	Complete	TRUE	Decrease
77300	Basic radiation dosime	Surface Radionuclide Hi	April 2014	20			ASTRO	0.62	MPC List / Codes Reported Toge	October 2010	XXX	0.62	1.28	NA	0.03	1,349,820	FALSE			TRUE	On 8-21-12, the Joint Work	February 2014, Oct	44, 28/	complete	TRUE	Maintain
77301	Intensity modulated r	IMRT - PE Only	April 2013	28			ASTRO	New PE Inputs. 7.99. CPT Ass	CMS Fastest Growing / CMS Rec	October 2008	XXX	7.99	46.91	NA	0.56	143,270	TRUE	Nov 2009	Yes	FALSE					TRUE	Maintain
77305	Teletherapy, isodose p	Isodose Calculation witl	April 2014	20			ASTRO	Deleted from CPT	Codes Reported Together 75% c	October 2010							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77306	Teletherapy isodose p	Isodose Calculation witl	April 2014	20				1.40	Codes Reported Together 75% c	October 2010	XXX	1.40	2.84	NA	0.07	2,027	FALSE			FALSE					TRUE	Decrease
77307	Teletherapy isodose p	Isodose Calculation witl	April 2014	20				2.90	Codes Reported Together 75% c	October 2010	XXX	2.90	5.33	NA	0.15	40,701	FALSE			FALSE					TRUE	Decrease
77310	Teletherapy, isodose p	Isodose Calculation witl	April 2014	20			ASTRO	Deleted from CPT	Codes Reported Together 75% c	October 2010							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77315	Teletherapy, isodose p	Isodose Calculation witl	April 2014	20			ASTRO	Deleted from CPT	Codes Reported Together 75% c	October 2010							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77316	Brachytherapy isodos	Isodose Calculation witl	April 2014	20				1.50	Codes Reported Together 75% c	October 2012	XXX	1.40	5.29	NA	0.09	4,610	FALSE			FALSE					TRUE	Decrease
77317	Brachytherapy isodos	Isodose Calculation witl	April 2014	20				1.83	Codes Reported Together 75% c	October 2012	XXX	1.83	6.96	NA	0.11	3,179	FALSE			FALSE					TRUE	Decrease
77318	Brachytherapy isodos	Isodose Calculation witl	October 2015	21				2.90	Codes Reported Together 75% c	October 2012	XXX	2.90	9.61	NA	0.17	5,949	FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Decrease
77326	Brachytherapy isodos	Isodose Calculation witl	April 2014	20				Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77327	Brachytherapy isodos	Isodose Calculation witl	April 2014	20			ASTRO	Deleted from CPT	Codes Reported Together 75% c	October 2010							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77328	Brachytherapy isodos	Isodose Calculation witl	April 2014	20				Deleted from CPT	Codes Reported Together 75% c	October 2012							FALSE			TRUE	On 8-21-12, the Joint Work	February 2014	44	Complete	TRUE	Deleted from CPT
77332	Treatment devices, de	RAW	January 2016	40	RUC		ASTRO	0.54	CMS High Expenditure Procedur	April 2015	XXX	0.45	0.74	NA	0.03	75,801	FALSE			FALSE					TRUE	Maintain
77333	Treatment devices, de	RAW	January 2016	40	RUC		ASTRO	0.84	CMS High Expenditure Procedur	April 2015	XXX	0.75	3.09	NA	0.05	12,128	FALSE			FALSE					TRUE	Maintain
77334	Treatment devices, design and construction; c		January 2016	40	RUC		ASTRO	1.24	MPC List / RUC request / CMS H	October 2010	XXX	1.15	2.47	NA	0.05	845,243	FALSE			FALSE					TRUE	Maintain
77336	Continuing medical ph	Continuing Medical Phy	April 2013	31			ASTRO	New PE Inputs	CMS Request - Final Rule for 20	October 2012	XXX	0.00	2.31	NA	0.06	412,038	FALSE			FALSE					TRUE	PE Only
77338	Multi-leaf collimator (	IMRT - PE Only	April 2013	28				New PE Inputs	Services with Stand-Alone PE Pr	October 2012	XXX	4.29	9.27	NA	0.21	165,179	FALSE			FALSE					TRUE	PE Only
77371	Radiation treatment d	Radiation Treatment De	April 2009	30			ASTRO	New PE inputs	CMS Request - Practice Expense	NA	XXX	0.00	0.00	0.00	0.00	100	FALSE			FALSE					TRUE	PE Only
77372	Radiation treatment d	Radiation Treatment De	October 2013	18				New PE Inputs	Services with Stand-Alone PE	Procedure Time	XXX	0.00	30.62	NA	0.15	818	FALSE			FALSE					TRUE	PE Only
77373	Stereotactic body radi	Radiation Treatment De	October 2013	18			ACR, ASTR	New PE inputs	Services with Stand-Alone PE Pr	July 2012	XXX	0.00	33.38	NA	0.21	33,144	FALSE			FALSE					TRUE	PE Only
77385	Intensity modulated r	Radiation Treatment De	January 2014	14			ACRO, AST	PE Only, revised introductory	Services with Stand-Alone PE Pr	January 2014	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE		October 2013	28	Complete	TRUE	PE Only
77386	Intensity modulated r	Radiation Treatment De	January 2014	14			ACRO, AST	PE Only, revised introductory	Services with Stand-Alone PE Pr	January 2014	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE		October 2013	28	Complete	TRUE	PE Only
77387	Guidance for localizat	Radiation Treatment De	January 2014	14			ACRO, AST	0.58	Services with Stand-Alone PE Pr	January 2014	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE		October 2013	28	Complete	TRUE	Decrease
77401	Radiation treatment d	Radiation Treatement D	January 2020	31				New PE Inputs	High Volume Growth5	October 2018	XXX	0.00	1.25	NA	0.01	221,049	FALSE			TRUE	In October 2018, this servic	May 2019	08	Withdraw	TRUE	PE Only
77402	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	PE Only, revised introductory	Services with Stand-Alone PE Pr	October 2012	XXX	0.00	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC mee	October 2013 and	28 & 45	Complete	TRUE	PE Only
77403	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77404	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77406	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77407	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	PE Only, revised introductory	Services with Stand-Alone PE Pr	October 2012	XXX	0.00	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	PE Only
77408	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77409	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77411	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77412	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	PE Only, revised introductory	Services with Stand-Alone PE Pr	October 2012	XXX	0.00	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	PE Only
77413	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77414	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77416	Radiation treatment d	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Services with Stand-Alone PE Pr	October 2012							FALSE			TRUE	At the April 2013 RUC mee	October 2013	28	Complete	TRUE	Deleted from CPT
77418	Intensity modulated t	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	CMS Fastest Growing / Services	October 2008							TRUE	Nov 2009	Yes	TRUE		October 2013	28	Complete	TRUE	Deleted from CPT
77421	Stereoscopic X-ray gui	Radiation Treatment De	January 2014	14			ACRO, AST	Deleted from CPT	Codes Reported Together 75% c	February 2010							FALSE			TRUE	In Jan 2012, the specialty ir	October 2013	28	Complete	TRUE	Deleted from CPT
77422	High energy neutron r	High Energy Neutron Ra	April 2015	35	RUC		AAOS, ASP	Contractor Price	CMS Request - Final Rule for 20	November 2014							FALSE			FALSE					TRUE	Maintain
77423	High energy neutron r	High Energy Neutron Ra	April 2015	35	RUC		AAOS, ASP	Contractor Price	CMS Request - Final Rule for 20	November 2014	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	Maintain
77427	Radiation treatment n	Radiation Treatment M	January 2016	54			ASTRO	3.45. Remove from high E/M	Site of Service Anomaly / High L	September 2007	XXX	3.37	1.88	1.88	0.25	1,043,579	FALSE			TRUE	In October 2008 the RUC R	June 2009	21	Complete	TRUE	Decrease
77435	Stereotactic body radi	RAW	January 2017	30				Remove from screen	High Volume Growth4	October 2016	XXX	11.87	5.81	5.81	0.86	38,142	FALSE			FALSE					TRUE	Remove from screen
77470	Special treatment pro	Special Radiation Treatr	January 2016	41			ASTRO	2.03	CMS High Expenditure Procedur	July 2015	XXX	2.03	1.73	NA	0.10	91,885	FALSE			FALSE					TRUE	Decrease
77520	Proton treatment deli	Proton Beam Treatmen	April 2019	19			ASTRO	New PE Inputs	Contractor Priced High Volume	October 2018	XXX	0.00	0.00	0.00	0.00	256	FALSE			FALSE					TRUE	PE Only
77522	Proton treatment deli	Proton Beam Treatmen	April 2019	19			ASTRO	New PE Inputs	Contractor Priced High Volume	January 2018	XXX	0.00	0.00	0.00	0.00	15,881	FALSE			FALSE					TRUE	PE Only
77523	Proton treatment deli	Proton Beam Treatmen	April 2019	19			ASTRO	New PE Inputs	High Volume Growth4 / Contrac	October 2016	XXX	0.00	0.00	0.00	0.00	47,302	FALSE			FALSE					TRUE	PE Only
77525	Proton treatment deli	Proton Beam Treatmen	April 2019	19			ASTRO	New PE Inputs	Contractor Priced High Volume	October 2018	XXX	0.00	0.00	0.00	0.00	20,144	FALSE			FALSE					TRUE	PE Only
77600	Hyperthermia, extern	Hyperthermia - PE Only	April 2013	30				New PE Inputs	Services with Stand-Alone PE Pr	October 2012	XXX	1.31	12.92	NA	0.10	5,464	FALSE			FALSE					TRUE	PE Only
77767	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO, AC	1.05	Codes Reported Together 75% c	October 2014	XXX	1.05	6.09	NA	0.08	5,362	FALSE			FALSE		October 2014	28/29	Complete	TRUE	Decrease
77768	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO, AC	1.40	Codes Reported Together 75% c	October 2014	XXX	1.40	9.17	NA	0.10	7,665	FALSE			FALSE		October 2014	28/29	Complete	TRUE	Decrease
77770	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO, AC	1.95	Codes Reported Together 75% c	October 2014	XXX	1.95	8.07	NA	0.11	17,117	FALSE			FALSE		October 2014	28/29	Complete	TRUE	Decrease
77771	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO, AC	3.80	Codes Reported Together 75% c	October 2014	XXX	3.80	13.63	NA	0.23	17,697	FALSE			FALSE		October 2014	28/29	Complete	TRUE	Decrease
77772	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO, AC	5.40	Codes Reported Together 75% c	October 2014	XXX	5.40	20.66	NA	0.35	4,164	FALSE			FALSE		October 2014	28/29	Complete	TRUE	Decrease
77776	Interstitial radiation s	Interstitial Radiation So	April 2015	17			ACR, ASTR	Deleted from CPT	Codes Reported Together 75% c	February 2015							FALSE			FALSE		February 2015	35	Complete	TRUE	Deleted from CPT
77777	Interstitial radiation s	Interstitial Radiation So	April 2015	17			ACR, ASTR	Deleted from CPT	Codes Reported Together 75% c	February 2015							FALSE			FALSE		February 2015	35	Complete	TRUE	Deleted from CPT
77778	Interstitial radiation s	Interstitial Radiation So	October 2015	21			ACR, ASTR	8.78	Codes Reported Together 75% c	October 2012	000	8.78	16.56	NA	0.46	4,806	FALSE			TRUE	The Joint Workgroup recor	February 2015	35	Complete	TRUE	Decrease
77781	Deleted from CPT	Brachytherapy	October 2008	26			ASTRO	Deleted from CPT	CMS Fastest Growing	October 2008							FALSE			TRUE	Deleted from CPT at Febru	February 2008	36	Code Dele	TRUE	Deleted from CPT
77782	Deleted from CPT	Brachytherapy	February 2008	S			ASTRO	Deleted from CPT	High Volume Growth1 / CMS Fa	February 2008							FALSE			TRUE	Deleted from CPT at Febru	February 2008	36	Code Dele	TRUE	Deleted from CPT
77784	Deleted from CPT	Brachytherapy	February 2008	S			ASTRO	Deleted from CPT	CMS Fastest Growing	February 2008							FALSE			TRUE	Deleted from CPT at Febru	February 2008	36	Code Dele	TRUE	Deleted from CPT
77785	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO	Deleted from CPT	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE								FALSE			TRUE	In October 2012, the Joint	October 2014	28/29	Complete	TRUE	Deleted from CPT
77786	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO	Deleted from CPT	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE								FALSE			TRUE	In October 2012, the Joint	October 2014	28/29	Complete	TRUE	Deleted from CPT
77787	Remote afterloading h	Surface Radionuclide Hi	January 2015	16			ASTRO	Deleted from CPT	High Volume Growth1 / CMS Fa	October 2012							FALSE			TRUE	In October 2012, the Joint	October 2014	28/29	Complete	TRUE	Deleted from CPT
77790	Supervision, handling,	Interstitial Radiation So	October 2015	21			ACR, ASTR	0.00	Codes Reported Together 75% c	October 2012	XXX	0.00	0.44	NA	0.01	145	FALSE			TRUE	The Joint Workgroup recor	February 2015	35	Complete	TRUE	Decrease
78000	Thyroid uptake; single	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78001	Thyroid uptake; multi	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78003	Thyroid uptake; stimu	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78006	Thyroid imaging, with	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78007	Thyroid imaging, with	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization ove	April 2011							FALSE			TRUE	Specialty requests referral	February 2012	13	Complete	TRUE	Deleted from CPT
78010	Thyroid imaging; only	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78011	Thyroid imaging; with	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	Deleted from CPT	Harvard Valued - Utilization over	30,000							FALSE			TRUE	Identified with 78007. The	February 2012	13	Complete	TRUE	Deleted from CPT
78012	Thyroid uptake, single	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	0.19	Harvard Valued - Utilization over	30,000	XXX	0.19	2.16	NA	0.05	1,653	FALSE			TRUE	Identified with 78007 and I	February 2012	13	Complete	TRUE	Decrease
78013	Thyroid imaging (inclu	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	0.37	Harvard Valued - Utilization over	30,000	XXX	0.37	5.33	NA	0.05	1,711	FALSE			TRUE	Identified with 78007 and I	February 2012	13	Complete	TRUE	Decrease
78014	Thyroid imaging (inclu	Thyroid Uptake/Imagin	April 2012	22			ACR, ACNM	0.50	Harvard Valued - Utilization over	30,000	XXX	0.50	6.47	NA	0.06	18,954	FALSE			TRUE	Identified with 78007 and I	February 2012	13	Complete	TRUE	Decrease
78070	Parathyroid planar im	Parathyroid Imaging	January 2016	54			ACR, ACNM	0.80	Harvard Valued - Utilization ove	April 2011	XXX	0.80	7.80	NA	0.08	13,220	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78071	Parathyroid planar im	Parathyroid Imaging	January 2016	54			ACR, ACNM	1.20	Harvard Valued - Utilization ove	April 2011	XXX	1.20	9.06	NA	0.10	8,974	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78072	Parathyroid planar im	Parathyroid Imaging	January 2016	54			ACR, ACNM	1.60	Harvard Valued - Utilization ove	April 2011	XXX	1.60	11.34	NA	0.10	12,267	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78223	Hepatobiliary ductal s	Hepatobiliary Ductal Sy	February 2011	12			ACR, SNM	Deleted from CPT	Harvard Valued - Utilization ove	October 2009							FALSE			TRUE	The specialties will be subr	October 2010	21	Complete	TRUE	Deleted from CPT
78226	Hepatobiliary system	Hepatobiliary System In	February 2011	12			ACR, SNM	0.74	Harvard Valued - Utilization over	100,000	XXX	0.74	8.80	NA	0.09	61,197	FALSE			FALSE					TRUE	Decrease
78227	Hepatobiliary system	Hepatobiliary System In	February 2011	12			ACR, SNM	0.90	Harvard Valued - Utilization over	100,000	XXX	0.90	11.97	NA	0.09	64,389	FALSE			FALSE					TRUE	Decrease
78278	Acute gastrointestinal	Acute GI Blood Loss Ima	September 2011	34			ACR, SNM	0.99	Harvard Valued - Utilization ove	April 2011	XXX	0.99	9.16	NA	0.09	26,257	FALSE			FALSE					TRUE	Maintain
78300	Bone and/or joint ima	Bone Imaging	April 2016	38			ACNM, AC	0.62	CMS High Expenditure Procedur	July 2015	XXX	0.62	6.06	NA	0.08	6,808	FALSE			FALSE					TRUE	Maintain
78305	Bone and/or joint ima	Bone Imaging	April 2016	38			ACNM, AC	0.83	CMS High Expenditure Procedur	July 2015	XXX	0.83	7.27	NA	0.08	1,645	FALSE			FALSE					TRUE	Maintain
78306	Bone and/or joint ima	Bone Imaging	April 2016	38			ACNM, AC	0.86	CMS High Expenditure Procedur	July 2015	XXX	0.86	7.86	NA	0.08	262,283	FALSE			FALSE					TRUE	Maintain
78429	Myocardial imaging, p	Myocardial PET	January 2019	13			ACC, ACR,	1.76	High Volume Growth4	May 2018	XXX	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78430	Myocardial imaging, p	Myocardial PET	January 2019	13			ACC, ACR,	1.67	High Volume Growth4	May 2018	XXX	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78431	Myocardial imaging, p	Myocardial PET	January 2019	13			ACC, ACR,	1.90	High Volume Growth4	May 2018	XXX	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78432	Myocardial imaging, p	Myocardial PET	January 2019	13			ACC, ACR,	2.07	High Volume Growth4	May 2018	XXX	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78433	Myocardial imaging, p	Myocardial PET	January 2019	13			ACC, ACR,	2.26	High Volume Growth4	May 2018	XXX	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78434	Absolute quantitation	Myocardial PET	January 2019	13			ACC, ACR,	0.63	High Volume Growth4	May 2018	ZZZ	0.00	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase

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92540	Basic vestibular evalu	EOG VNG	April 2014	24			AAN, ASH/	1.50		Codes Reported Together 95% or More		XXX	1.50	1.66	NA	0.05	89,363	FALSE			FALSE							TRUE	Decrease
92541	Spontaneous nystagm	EOG VNG	April 2014	24			AAN, ASH/	0.40		Codes Reported Together 95% c	February 2008	XXX	0.40	0.32	NA	0.02	13,573	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Maintain
92542	Positional nystagmus	EOG VNG	April 2014	24			AAN, ASH/	0.48		Codes Reported Together 95% c	February 2008	XXX	0.48	0.36	NA	0.02	19,332	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Increase
92543	Caloric vestibular test	Vestibular Caloric Irriga	January 2015	18			AAA, AAN,	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	The RUC discussed the con	October 2014	54	Complete	TRUE	Deleted from CPT
92544	Optokinetic nystagmu	EOG VNG	April 2014	24			AAN, ASH/	0.27		Codes Reported Together 95% c	February 2008	XXX	0.27	0.24	NA	0.02	2,943	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Increase
92545	Oscillating tracking te	EOG VNG	April 2014	24			AAN, ASH/	0.25		Codes Reported Together 95% c	February 2008	XXX	0.25	0.22	NA	0.02	3,622	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Increase
92546	Sinusoidal vertical axis	EOG VNG	April 2014	24				Editorial change only		CMS-Other - Utilization over 25(	February 2014	XXX	0.29	3.16	NA	0.03	43,026	FALSE			TRUE	Referred to the CPT Editori	February 2014	87	Complete	TRUE	Maintain
92547	Use of vertical electro	EOG VNG	April 2014	24				Editorial change only		CMS-Other - Utilization over 25(	February 2014	ZZZ	0.00	0.29	NA	0.00	26,526	FALSE			TRUE	Referred to the CPT Editori	February 2014	87	Complete	TRUE	Maintain
92548	Computerized dynami	Computerized Dynamic	January 2019	16			AAA, AAN,	0.76		CMS-Other - Utilization over 25(	February 2014	XXX	0.67	0.75	NA	0.03	51,157	FALSE			TRUE	In 2014 the RUC referred tl	September 2018 /	35	complete	TRUE	Increase
92549	Computerized dynami	Computerized Dynamic	January 2019	16	RUC			0.96		CMS-Other - Utilization over 25(	September 2018	XXX	0.87	0.94	NA	0.05		FALSE			FALSE		September 2018	35	complete	TRUE	Increase
92550	Tympanometry and re	Bundled Audiology Test	April 2009	22			ASHA, AAC	0.35		Codes Reported Together 95% or More		XXX	0.35	0.28	NA	0.02	231,898	FALSE			FALSE					TRUE	Decrease
92557	Comprehensive audio	Bundled Audiology Test	April 2009	22			ASHA, AAC	0.60	work RVU and clinical st	Codes Reported Together 95% c	February 2008	XXX	0.60	0.48	0.31	0.04	1,255,685	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Decrease
92558	Evoked otoacoustic er	Otoacoustic Emissions I	April 2011	35			ASHA	0.17		CMS Fastest Growing	February 2011	XXX	0.17	0.10	0.07	0.01		FALSE			FALSE		February 2011			TRUE	Increase
92567	Tympanometry (impe	Bundled Audiology Test	April 2009	22			ASHA, AAC	0.20	work RVU and clinical st	Codes Reported Together 95% c	February 2008	XXX	0.20	0.27	0.10	0.01	922,916	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Decrease
92568	Acoustic reflex testing	Bundled Audiology Test	April 2009	22			ASHA, AAC	0.29	work RVU and clinical st	Codes Reported Together 95% c	February 2008	XXX	0.29	0.14	0.13	0.02	5,046	FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Complete	TRUE	Decrease
92569	Deleted from CPT	Bundled Audiology Test	April 2009	22			ASHA, AAC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	February 2009	54	Code Dele	TRUE	Deleted from CPT
92570	Acoustic immittance t	Bundled Audiology Test	October 2015	21			ASHA, AAC	0.55		Codes Reported Together 95% or More		XXX	0.55	0.38	0.28	0.04	38,849	FALSE			FALSE					TRUE	Decrease
92584	Electrocochleography	Auditory Evoked Potent	April 2019	06			AAA, AAO-	1.00		CMS-Other - Utilization over 30,	February 2019	XXX	1.00	2.43	NA	0.05	11,016	FALSE			FALSE					TRUE	Increase
92585	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAO-	Deleted from CPT		CMS-Other - Utilization over 30,	October 2017						34,565	FALSE			TRUE	In October 2017, the RAW	February 2019	19	complete	TRUE	Deleted from CPT
92586	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAO-	Deleted from CPT		CMS-Other - Utilization over 30,	February 2019						1,425	FALSE			FALSE		February 2019	19	complete	TRUE	Deleted from CPT
92587	Distortion product evo	Otoacoustic Emissions I	April 2011	35			ASHA	0.45		CMS Fastest Growing	October 2008	XXX	0.35	0.28	NA	0.02	58,068	FALSE			TRUE	The specialty noted that th	October 2010	41	Complete	TRUE	Increase
92588	Distortion product evo	Otoacoustic Emissions I	April 2011	35			ASHA	0.60		CMS Fastest Growing		XXX	0.55	0.42	NA	0.02	85,077	FALSE			FALSE		February 2011			TRUE	Increase
92597	Evaluation for use anc	Speech Language Patho	February 2009	30			ASHA	1.48	work RVU and clinical st	CMS Request/Speech Language	NA	XXX	1.26	0.77	NA	0.05	2,839	FALSE			FALSE					TRUE	Decrease
92605	Evaluation for prescri	Eval of Rx for Non-Spee	April 2011	35			ASHA	1.75		CMS Request/Speech Language Pathology Request		XXX	1.75	0.85	0.68	0.14		FALSE			TRUE	The specialty society after	February 2011	58	Complete	TRUE	Increase
92606	Therapeutic service(s)	Speech Language Patho	February 2010	28			ASHA	1.40	work RVU and clinical st	CMS Request/Speech Language Pathology Request		XXX	1.40	0.91	0.54	0.13		FALSE			FALSE					TRUE	Decrease
92607	Evaluation for prescri	Speech Language Patho	February 2010	28			ASHA	1.85	work RVU and clinical st	CMS Request/Speech Language Pathology Request		XXX	1.85	1.75	NA	0.06	544	FALSE			FALSE					TRUE	Decrease
92608	Evaluation for prescri	Speech Language Patho	February 2010	28			ASHA	0.70	work RVU and clinical st	CMS Request/Speech Language Pathology Request		ZZZ	0.70	0.73	NA	0.04	220	FALSE			FALSE					TRUE	Decrease
92609	Therapeutic services f	Speech Language Patho	February 2010	28			ASHA	1.50	work RVU and clinical st	CMS Request/Speech Language Pathology Request		XXX	1.50	1.51	NA	0.05	14,910	FALSE			FALSE					TRUE	Decrease
92610	Evaluation of oral and	Speech Language Patho	October 2020	23			ASHA, AAC	Maintain		CMS Request/Speech Language	NA	XXX	1.30	1.13	0.68	0.05	22,897	FALSE			FALSE					TRUE	Decrease
92611	Motion fluoroscopic e	Speech Language Patho	April 2009	39			ASHA	1.34	work RVU and clinical st	CMS Request/Speech Language	NA	XXX	1.34	1.26	NA	0.09	9,673	FALSE			FALSE					TRUE	Decrease
92618	Evaluation for prescri	Eval of Rx for Non-Spee	April 2011	35			ASHA	0.65		CMS Request/Speech Language Pathology Request		ZZZ	0.65	0.26	0.25	0.05		FALSE			FALSE		February 2011	58		TRUE	Increase
92620	Evaluation of central a	Audiology Services	October 2008	17			ASHA, AAC	1.50		CMS Request - Audiology Servic	NA	XXX	1.50	1.15	0.79	0.05	818	FALSE			FALSE					TRUE	Decrease
92621	Evaluation of central a	Audiology Services	October 2008	17			ASHA, AAC	0.35		CMS Request - Audiology Servic	NA	ZZZ	0.35	0.30	0.19	0.01	43	FALSE			FALSE					TRUE	Decrease
92625	Assessment of tinnitu	Audiology Services	October 2008	17			ASHA, AAC	1.15		CMS Request - Audiology Servic	NA	XXX	1.15	0.83	0.60	0.05	9,371	FALSE			FALSE					TRUE	Decrease
92626	Evaluation of auditory	Audiology Services	October 2018	30			AAA, ASH/	1.40		CMS Request - Audiology Servic	NA	XXX	1.40	1.17	0.74	0.05	29,623	TRUE	July 2014	Yes	TRUE	In October 2016, this servic	May 2018	34	Yes	TRUE	Decrease
92627	Evaluation of auditory	Audiology Services	October 2018	30			ASHA, AAC	0.33		CMS Request - Audiology Servic	NA	ZZZ	0.33	0.28	0.18	0.01	7,594	FALSE			FALSE					TRUE	Decrease
92640	Diagnostic analysis wi	Audiology Services	October 2008	17			ASHA, AAC	1.76		CMS Request - Audiology Servic	NA	XXX	1.76	1.50	0.95	0.05	11	FALSE			FALSE					TRUE	Decrease
92650	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAO-	0.25		CMS-Other - Utilization over 30,	February 2019	XXX	0.25	0.56	NA	0.02		FALSE			FALSE		February 2019	19	complete	TRUE	Decrease
92651	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAO-	1.00		CMS-Other - Utilization over 30,	February 2019	XXX	1.00	1.57	NA	0.05		FALSE			FALSE		February 2019	19	complete	TRUE	Increase
92652	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAO-	1.50		CMS-Other - Utilization over 30,	February 2019	XXX	1.50	1.84	NA	0.09		FALSE			FALSE		February 2019	19	complete	TRUE	Increase
92653	Auditory evoked pote	Auditory Evoked Potent	April 2019	06			AAA, AAN,	1.05		CMS-Other - Utilization over 30,	February 2019	XXX	1.05	1.41	NA	0.05		FALSE			FALSE		February 2019	19	complete	TRUE	Increase
92920	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	9.00		MPC List	October 2010	000	9.85	NA	3.43	2.17	24,084	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92921	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	4.00		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92924	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	11.00		MPC List	October 2010	000	11.74	NA	4.09	2.59	2,282	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92925	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	5.00		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92928	Percutaneous transca	Percutaneous Coronary	January 2012	10			ACC	10.49		MPC List	October 2010	000	10.96	NA	3.81	2.42	254,826	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92929	Percutaneous transca	Percutaneous Coronary	January 2012	10			ACC	4.44		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92933	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	12.32		MPC List	October 2010	000	12.29	NA	4.27	2.74	19,416	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92934	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	5.50		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92937	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	10.49		MPC List	October 2010	000	10.95	NA	3.80	2.42	18,930	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92938	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	6.00		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92941	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	12.32		MPC List	October 2010	000	12.31	NA	4.28	2.72	41,108	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92943	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	12.32		MPC List	October 2010	000	12.31	NA	4.28	2.74	9,129	FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92944	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	6.00		MPC List	October 2010	ZZZ	0.00	0.00	0.00	0.00		FALSE			TRUE		October 2011	21	Complete	TRUE	Decrease
92960	Cardioversion, electiv	Cardioversion	October 2010	19			ACC	2.25		Harvard Valued - Utilization ove	October 2009	000	2.00	2.49	1.01	0.15	201,622	FALSE			FALSE					TRUE	Maintain
92973	Percutaneous translur	RAW	October 2017	19				Remove from screen		High Volume Growth2	April 2013	ZZZ	3.28	NA	1.14	0.74	2,130	FALSE			FALSE					TRUE	Maintain
92980	Transcatheter placem	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
92981	Transcatheter placem	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
92982	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List / Harvard-Valued Ann	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
92984	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
92986	Percutaneous balloon	Valvuloplasty	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008	090	22.60	NA	10.90	4.97	2,857	FALSE			FALSE					TRUE	Remove from Screen
92992	Atrial septectomy or s	Atrial Septostomy	January 2020	13				Deleted from CPT		CMS Request - Final Rule for 20	October 2018						76	FALSE			TRUE	In January 2019, the RUC ic	September 2019	16	yes	TRUE	Deleted from CPT
92993	Atrial septectomy or s	Atrial Septostomy	January 2020	13				Deleted from CPT		CMS Request - Final Rule for 20	October 2018						1	FALSE			TRUE	In January 2019, the RUC ic	September 2019	16	yes	TRUE	Deleted from CPT
92995	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
92996	Percutaneous translur	Percutaneous Coronary	January 2012	10			ACC	Deleted from CPT		MPC List	October 2010							FALSE			TRUE	Specialty society is plannin	October 2011	21	Deleted fr	TRUE	Deleted from CPT
93000	Electrocardiogram, ro	Complete Electrocardio	April 2019	20			ACC	0.17		CMS High Expenditure Procedur	September 2011	XXX	0.17	0.24	NA	0.02	11,883,535	FALSE			FALSE					TRUE	Maintain
93005	Electrocardiogram, ro	Complete Electrocardio	April 2019	20			ACC	0.00		High Volume Growth1 / CMS Hi	February 2008	XXX	0.00	0.18	NA	0.01	460,887	FALSE			FALSE					TRUE	PE Only
93010	Electrocardiogram, ro	Complete Electrocardio	April 2019	20			ACC	0.17		MPC List / CMS High Expenditur	October 2010	XXX	0.17	0.06	0.06	0.01	18,866,949	FALSE			FALSE					TRUE	Maintain
93012	Deleted from CPT	External Cardiovascular	April 2010	25			ACC	Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			FALSE		February 2010	57		TRUE	Deleted from CPT
93014	Deleted from CPT	External Cardiovascular	April 2010	25			ACC	Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			FALSE		February 2010	57		TRUE	Deleted from CPT
93015	Cardiovascular stress t	Cardiovascular Stress Te	April 2012	47			ACC	0.75. CPT Assistant published		Codes Reported Together 75% c	February 2010	XXX	0.75	1.26	NA	0.05	999,644	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the spec	October 2010	42	Complete	TRUE	Maintain
93016	Cardiovascular stress t	Cardiovascular Stress Te	April 2012	47			ACC	0.45		Codes Reported Together 75% c	February 2010	XXX	0.45	0.16	0.16	0.02	1,047,732	FALSE			FALSE					TRUE	Maintain
93017	Cardiovascular stress t	Cardiovascular Stress Te	April 2010	45			ACC	New PE inputs		High Volume Growth1 / CMS Re	February 2008	XXX	0.00	0.99	NA	0.02	96,453	FALSE			FALSE					TRUE	PE Only
93018	Cardiovascular stress t	Cardiovascular Stress Te	April 2012	47			ACC	0.30		Codes Reported Together 75% c	February 2010	XXX	0.30	0.11	0.11	0.01	1,241,516	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the spec	October 2010	42	Complete	TRUE	Maintain
93025	Microvolt T-wave alte	Microvolt T-Wave Asse	October 2008	18			ACC	New PE Inputs		CMS Request - Practice Expense	NA	XXX	0.75	3.15	NA	0.04	213	FALSE			FALSE					TRUE	PE Only
93040	Rhythm ECG, 1-3 lead	Rhythm EKG	October 2009	34			ACC	0.15		Havard Valued - Utilization over	February 2009	XXX	0.15	0.20	NA	0.02	108,714	FALSE			FALSE					TRUE	Decrease
93041	Rhythm ECG, 1-3 lead	Rhythm EKG	October 2009	34			ACC	0.00 (PE only)		Havard Valued - Utilization over	February 2009	XXX	0.00	0.16	NA	0.01	12,914	FALSE			FALSE					TRUE	Maintain
93042	Rhythm ECG, 1-3 lead	Rhythm EKG	October 2009	34			ACC, ACEP	0.15		Havard Valued - Utilization over	October 2008	XXX	0.15	0.04	0.04	0.01	362,235	FALSE			FALSE					TRUE	Decrease
93224	External electrocardio	External Cardiovascular	April 2010	25			ACC	0.52		Harvard Valued - Utilization ove	October 2009	XXX	0.39	1.89	NA	0.03	284,557	FALSE			TRUE	The ACC and the Heart Rhy	February 2010	57	Revised	TRUE	Maintain
93225	External electrocardio	External Cardiovascular	April 2010	25			ACC	N/A no physician work		Harvard Valued - Utilization ove	October 2009	XXX	0.00	0.57	NA	0.01	110,328	FALSE			FALSE		February 2010	57		TRUE	Maintain
93226	External electrocardio	External Cardiovascular	April 2010	25			ACC	N/A no physician work		Harvard Valued - Utilization ove	October 2009	XXX	0.00	1.18	NA	0.01	154,751	FALSE			FALSE		February 2010	57		TRUE	Maintain
93227	External electrocardio	External Cardiovascular	April 2010	25			ACC	0.52		Harvard Valued - Utilization ove	October 2009	XXX	0.39	0.14	0.14	0.01	344,162	FALSE			TRUE	The ACC and the Heart Rhy	Feburary 2010	57	Revised	TRUE	Maintain
93228	External mobile cardic	External Cardiovascular	October 2020	20			ACC, HRS	0.52		Harvard Valued - Utilization ove	October 2009	XXX	0.52	0.19	0.19	0.04	186,123	FALSE			FALSE					TRUE	Maintain
93229	External mobile cardic	External Cardiovascular	October 2020	20			ACC, HRS	PE Only		Harvard Valued - Utilization ove	October 2009	XXX	0.00	20.46	NA	0.09	271,792	FALSE			FALSE					TRUE	PE Only
93230	Deleted from CPT	Cardiac Device Monitor	April 2009	31			ACC	Deleted from CPT		CMS Request - 2009 Final Rule,	NA							FALSE			TRUE	CMS stated that 93230 and	February 2010	57	Deleted	TRUE	Deleted from CPT
93231	Deleted from CPT	External Cardiovascular	April 2010	25				Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			FALSE		February 2010	57		TRUE	Deleted from CPT
93232	Deleted from CPT	External Cardiovascular	April 2010	25				Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			FALSE		February 2010	57		TRUE	Deleted from CPT
93233	Deleted from CPT	Cardiac Device Monitor	April 2009	31			ACC	Deleted from CPT		CMS Request - 2009 Final Rule,	NA							FALSE			TRUE	CMS stated that 93230 and	February 2010	57	Deleted	TRUE	Deleted from CPT
93235	Deleted from CPT	External Cardiovascular	April 2010	25				Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			FALSE		February 2010	57		TRUE	Deleted from CPT
93236	Deleted from CPT	Cardiovascular Stress Te	April 2009	38			ACC	Deleted from CPT		Harvard Valued - Utilization ove	February 2008							FALSE			TRUE	In February 2008 the Work	February 2010	57	Deleted	TRUE	Deleted from CPT
93237	Deleted from CPT	Wearable Cardiac Devic	February 2010	31			ACC	Deleted from CPT		Harvard Valued - Utilization ove	October 2009							FALSE			TRUE	The ACC and the Heart Rhy	February 2010	57	Complete	TRUE	Deleted from CPT
93268	External patient and, v	External Cardiovascular	April 2010	25			ACC	0.52		Harvard Valued - Utilization ove	October 2009	XXX	0.52	5.22	NA	0.04	11,689	FALSE			FALSE		February 2010	57		TRUE	Maintain
93270	External patient and, v	External Cardiovascular	April 2010	25			ACC	New PE inputs		Harvard Valued - Utilization ove	October 2009	XXX	0.00	0.25	NA	0.01	39,075	FALSE			FALSE		February 2010	57		TRUE	PE Only
93271	External patient and, v	External Cardiovascular	April 2010	25			ACC	New PE inputs		Harvard Valued - Utilization ove	October 2009	XXX	0.00	4.79	NA	0.01	54,627	FALSE			FALSE		February 2010	57		TRUE	PE Only
93272	External patient and, v	External Cardiovascular	April 2010	25			ACC	0.52		Harvard Valued - Utilization ove	October 2009	XXX	0.52	0.18	0.18	0.02	104,829	FALSE			FALSE		February 2010	57		TRUE	Maintain
93279	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.65		CMS High Expenditure Procedur	July 2015	XXX	0.65	1.25	NA	0.03	152,741	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93280	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.77		CMS High Expenditure Procedur	July 2015	XXX	0.77	1.47	NA	0.05	986,249	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain

93281	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.85		CMS High Expenditure Procedur	July 2015	XXX	0.85	1.54	NA	0.05	73,701	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Decrease
93282	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.85		CMS High Expenditure Procedur	July 2015	XXX	0.85	1.42	NA	0.05	115,690	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93283	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	1.15		CMS High Expenditure Procedur	July 2015	XXX	1.15	1.64	NA	0.05	214,401	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93284	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	1.25		CMS High Expenditure Procedur	July 2015	XXX	1.25	1.77	NA	0.05	246,603	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93285	Programming device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.52		CMS High Expenditure Procedur	July 2015	XXX	0.52	1.18	NA	0.03	40,620	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93286	Peri-procedural devic	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.30		CMS High Expenditure Procedur	July 2015	XXX	0.30	1.00	NA	0.02	20,480	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93287	Peri-procedural devic	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.45		CMS High Expenditure Procedur	July 2015	XXX	0.45	1.06	NA	0.03	12,854	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93288	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.43		CMS High Expenditure Procedur	July 2015	XXX	0.43	1.15	NA	0.02	242,876	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93289	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.75		CMS High Expenditure Procedur	July 2015	XXX	0.75	1.29	NA	0.05	97,500	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Decrease
93290	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.43		CMS High Expenditure Procedur	July 2015	XXX	0.43	1.07	NA	0.03	118,819	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93291	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.37		CMS High Expenditure Procedur	July 2015	XXX	0.37	1.02	NA	0.02	68,111	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Decrease
93292	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	0.43		CMS High Expenditure Procedur	July 2015	XXX	0.43	0.98	NA	0.03	1,142	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Maintain
93293	Transtelephonic rhyth	Cardiac Electrophysiolo	January 2017	23			ACC, HRS	0.31		CMS High Expenditure Procedur	July 2015	XXX	0.31	1.15	NA	0.02	50,828	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	Decrease
93294	Interrogation device e	Cardiac Electrophysiolo	January 2017	23			ACC, HRS	0.60		CMS High Expenditure Procedur	July 2015	XXX	0.60	0.24	0.24	0.04	1,162,316	FALSE			FALSE					TRUE	Decrease
93295	Interrogation device e	Cardiac Electrophysiolo	January 2017	23			ACC, HRS	0.74		CMS High Expenditure Procedur	July 2015	XXX	0.74	0.30	0.30	0.05	618,312	FALSE			FALSE					TRUE	Decrease
93296	Interrogation device e	Cardiac Electrophysiolo	October 2016	25			ACC, HRS	New PE inputs and Refer to C		CMS High Expenditure Procedur	July 2015	XXX	0.00	0.73	NA	0.01	1,298,857	FALSE			TRUE	In the NPRM for 2016 CMS	February 2017	Advisor	yes	TRUE	PE Only
93297	Interrogation device e	Cardiac Electrophysiolo	January 2017	23			ACC, HRS	0.52		CMS High Expenditure Procedur	July 2015	XXX	0.52	0.21	0.21	0.04	436,176	FALSE			FALSE					TRUE	Maintain
93298	Interrogation device e	Cardiac Electrophysiolo	January 2017	23			ACC, HRS	0.52		CMS High Expenditure Procedur	July 2015	XXX	0.52	0.21	0.21	0.04	718,193	FALSE			FALSE					TRUE	Maintain
93299	Interrogation device e	Cardiac Electrophysiolo	October 2018	22			ACC, HRS	Deleted from CPT		CMS High Expenditure Procedur	July 2015						790,455	FALSE			TRUE	In October 2018, the RUC r	February 2019	20	complete	TRUE	Deleted from CPT
93306	Echocardiography, tra	Complete Transthoracic	April 2019	21			ACC, ASE	1.46		CMS High Expenditure Procedur	July 2015	XXX	1.46	4.43	NA	0.07	7,396,555	FALSE			FALSE					TRUE	Decrease
93307	Echocardiography, tra	Transthoracic Echocard	April 2016	42			ACC	0.92		CMS Request - Practice Expense	NA	XXX	0.92	3.23	NA	0.06	26,672	FALSE			FALSE					TRUE	Maintain
93308	Echocardiography, tra	Transthoracic Echocard	April 2016	42			ACC	0.53		CMS Fastest Growing, Harvard V	October 2008	XXX	0.53	2.39	NA	0.03	435,885	FALSE			FALSE					TRUE	Maintain
93320	Doppler echocardiogr	Doppler Echocardiograp	January 2014	30			ACC	0.38		CMS Request - Practice Expense	February 2009	ZZZ	0.38	1.16	NA	0.02	365,942	FALSE			FALSE					TRUE	Maintain
93321	Doppler echocardiogr	Doppler Echocardiograp	January 2014	30			ACC	0.15		CMS-Other - Utilization over 25(	October 2013	ZZZ	0.15	0.62	NA	0.01	239,405	FALSE			FALSE					TRUE	Maintain
93325	Doppler echocardiogr	Doppler Echocardiograp	January 2014	30			ACC	0.07		CMS Request - Practice Expense	February 2009	ZZZ	0.07	0.66	NA	0.00	606,488	FALSE			FALSE					TRUE	Maintain
93350	Echocardiography, tra	Stress Transthoracic Ecl	October 2016	26	RUC		ACC, ASE	1.46; CPT Assistant article pu		Other - Identified by RUC / Code	April 2008	XXX	1.46	4.11	NA	0.07	95,788	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the spec	October 2010	42	Complete	TRUE	Decrease
93351	Echocardiography, tra	Stress Transthoracic Ecl	October 2016	26	RUC		ACC, ASE	1.75		CMS High Expenditure Procedur	July 2015	XXX	1.75	5.13	NA	0.09	241,940	FALSE			FALSE					TRUE	Maintain
93451	Right heart catheteriz	Diagnostic Cardiac Cath	April 2018	33			ACC	Remove from Modifier -51 ex		Codes Reported Together 95% or More / Modifier -		000	2.47	23.82	NA	0.48	44,232	FALSE			FALSE		October 2009	13		TRUE	Decrease
93452	Left heart catheterizat	Diagnostic Cardiac Cath	April 2011	28			ACC	4.32		Codes Reported Together 95% or More		000	4.50	22.80	NA	0.84	3,594	FALSE			FALSE		October 2009	13		TRUE	Decrease
93453	Combined right and le	Diagnostic Cardiac Cath	April 2011	28			ACC	5.98		Codes Reported Together 95% or More		000	5.99	28.76	NA	1.16	2,368	FALSE			FALSE		October 2009	13		TRUE	Decrease
93454	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	4.95		Codes Reported Together 95% or More		000	4.54	22.77	NA	0.88	127,375	FALSE			FALSE		October 2009	13		TRUE	Decrease
93455	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	6.15		Codes Reported Together 95% or More		000	5.29	25.34	NA	1.03	27,649	FALSE			FALSE		October 2009	13		TRUE	Decrease
93456	Catheter placement in	Diagnostic Cardiac Cath	April 2018	33			ACC	Remove from Modifier -51 Ex		Codes Reported Together 95% or More / Modifier -		000	5.90	28.29	NA	1.14	19,829	FALSE			FALSE		October 2009	13		TRUE	Decrease
93457	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	7.66		Codes Reported Together 95% or More		000	6.64	30.82	NA	1.30	3,711	FALSE			FALSE		October 2009	13		TRUE	Decrease
93458	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	6.51		Codes Reported Together 95% or More		000	5.60	25.90	NA	1.07	507,961	FALSE			FALSE		October 2009	13		TRUE	Decrease
93459	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	7.34		Codes Reported Together 95% or More		000	6.35	27.63	NA	1.24	90,436	FALSE			FALSE		October 2009	13		TRUE	Decrease
93460	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	7.88		Codes Reported Together 95% or More		000	7.10	30.59	NA	1.39	89,701	FALSE			FALSE		October 2009	13		TRUE	Decrease
93461	Catheter placement in	Diagnostic Cardiac Cath	April 2011	28			ACC	9.00		Codes Reported Together 95% or More		000	7.85	33.97	NA	1.51	14,051	FALSE			FALSE		October 2009	13		TRUE	Decrease
93462	Left heart catheterizat	Diagnostic Cardiac Cath	April 2011	28			ACC	3.73		Codes Reported Together 95% or More		ZZZ	3.73	1.60	1.60	0.82	6,479	FALSE			FALSE		October 2009	13		TRUE	Decrease
93463	Pharmacologic agent a	Diagnostic Cardiac Cath	April 2011	28			ACC	2.00		Codes Reported Together 95% or More		ZZZ	2.00	0.70	0.70	0.15	6,287	FALSE			FALSE		October 2009	13		TRUE	Decrease
93464	Physiologic exercise st	Diagnostic Cardiac Cath	April 2011	28			ACC	1.80		Codes Reported Together 95% or More		ZZZ	1.80	5.08	NA	0.10	1,054	FALSE			FALSE		October 2009	13		TRUE	Decrease
93501	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93503	Insertion and placeme	Insertion of Catheter	April 2018	33			ACR, ASA	2.00		CMS High Expenditure Procedur	July 2015	000	2.00	NA	0.38	0.17	71,386	FALSE			FALSE					TRUE	Decrease
93508	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93510	Deleted from CPT	Cardiac Catheterization	February 2009	31			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93511	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93514	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93524	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93526	Deleted from CPT	Cardiac Catheterization	February 2008	S			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93527	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93528	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93529	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93539	Deleted from CPT	Cardiac Catheterization	February 2008	S			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93540	Deleted from CPT	Cardiac Catheterization	February 2008	S			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93541	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93542	Deleted from CPT	Cardiac Catheterization	April 2010	26			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93543	Deleted from CPT	Cardiac Catheterization	February 2009	31			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93544	Deleted from CPT	Cardiac Catheterization	February 2008	S			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93545	Deleted from CPT	Cardiac Catheterization	February 2009	31			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93555	Deleted from CPT	Cardiac Catheterization	February 2009	31			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93556	Deleted from CPT	Cardiac Catheterization	February 2009	31			ACC	Deleted from CPT		Codes Reported Together 95% c	February 2008							FALSE			TRUE	Referred to the CPT Editori	October 2009	13	Deleted	TRUE	Deleted from CPT
93561	Indicator dilution stuc	Cardiac Output Measur	January 2018	27				0.77		Negative IWPUT	October 2017	ZZZ	0.00	NA	NA	0.00	6	FALSE			FALSE					TRUE	Increase
93562	Indicator dilution stuc	Cardiac Output Measur	January 2018	27				0.95		Negative IWPUT	October 2017	ZZZ	0.00	NA	NA	0.00	14	FALSE			FALSE					TRUE	Increase
93563	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	2.00		Codes Reported Together 95% or More		ZZZ	1.11	0.39	0.39	0.17	167	FALSE			FALSE		October 2009	13		TRUE	Decrease
93564	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	2.10		Codes Reported Together 95% or More		ZZZ	1.13	0.39	0.39	0.25	6	FALSE			FALSE		October 2009	13		TRUE	Decrease
93565	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	1.90		Codes Reported Together 95% or More		ZZZ	0.86	0.30	0.30	0.14	80	FALSE			FALSE		October 2009	13		TRUE	Decrease
93566	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	0.96		Codes Reported Together 95% or More		ZZZ	0.86	3.14	0.30	0.16	388	FALSE			FALSE		October 2009	13		TRUE	Decrease
93567	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	0.97		Codes Reported Together 95% or More		ZZZ	0.97	2.33	0.34	0.21	28,640	FALSE			FALSE		October 2009	13		TRUE	Decrease
93568	Injection procedure d	Diagnostic Cardiac Cath	April 2011	28			ACC	0.98		Codes Reported Together 95% or More		ZZZ	0.88	2.81	0.32	0.19	1,334	FALSE			TRUE		October 2009	13	Complete	TRUE	Decrease
93571	Intravascular Doppler	Coronary Flow Reserve	October 2017	13			ACC, SCAI	1.50		High Volume Growth4	October 2016	ZZZ	0.00	NA	NA	0.00	69,945	FALSE			FALSE					TRUE	Decrease
93572	Intravascular Doppler	Coronary Flow Reserve	October 2017	13			ACC, SCAI	1.00		High Volume Growth4	October 2017	ZZZ	0.00	NA	NA	0.00	12,600	FALSE			FALSE					TRUE	Decrease
93613	Intracardiac electroph	Cardiac Ablation Service	April 2021	07			ACC, HRS	5.23		CMS Fastest Growing / High Vol	October 2008	ZZZ	5.23	NA	2.27	1.17	80,773	FALSE			FALSE					TRUE	Decrease
93620	Comprehensive electr	Intracardiac Catheter A	April 2010	45			ACC	11.57		Codes Reported Together 75% c	February 2010	000	0.00	0.00	NA	0.00	8,849	FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Maintain
93621	Comprehensive electr	Cardiac Ablation Service	April 2021	07			ACC, HRS	1.75		High Volume Growth6	October 2019	ZZZ	0.00	0.00	NA	0.00	29,892	FALSE			FALSE					TRUE	Decrease
93623	Programmed stimulat	Pacing Heart Stimulatio	April 2019	22			ACC, HRS	Referral to CPT for parenthet		CMS-Other - Utilization over 30,	October 2018	ZZZ	0.00	0.00	NA	0.00	38,626	FALSE			TRUE	In April 2019, the specialty	May 2019	EC-N	Complete	TRUE	Decrease
93641	Electrophysiologic eva	Insertion/Removal of P	September 2014	21			ACC	Maintain work RVU and adjus		Codes Reported Together 75% c	February 2010	000	0.00	0.00	NA	0.00	14,210	FALSE			TRUE	33213 - This code, when or	February 2011	13	Complete	TRUE	Maintain
93651	Intracardiac catheter a	Bundling EPS with Tran	January 2012	11			ACC, HRS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Deleted from CPT
93652	Intracardiac catheter a	Bundling EPS with Tran	January 2012	11			ACC, HRS	Deleted from CPT		CMS Fastest Growing/Codes Re	October 2008							FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Deleted from CPT
93653	Comprehensive electr	Cardiac Ablation Service	April 2021	07			ACC, HRS	15.00		Codes Reported Together 75% c	October 2011	000	14.75	NA	6.40	3.29	31,821	FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Decrease
93654	Comprehensive electr	Cardiac Ablation Service	April 2021	07			ACC, HRS	18.10		Codes Reported Together 75% c	October 2011	000	19.75	NA	8.55	4.41	7,750	FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Decrease
93655	Intracardiac catheter a	Cardiac Ablation Service	April 2021	07			ACC, HRS	7.00		Codes Reported Together 75% c	October 2011	ZZZ	7.50	NA	3.27	1.67	31,147	FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Decrease
93656	Comprehensive electr	Cardiac Ablation Service	April 2021	07			ACC, HRS	17.00		Codes Reported Together 75% c	October 2011	000	19.77	NA	8.63	4.42	53,327	FALSE			TRUE	In October 2019, the Work	October 2020	61	complete	TRUE	Decrease
93657	Additional linear or fo	Cardiac Ablation Service	April 2021	07			ACC, HRS	7.00		Codes Reported Together 75% c	October 2011	ZZZ	7.50	NA	3.26	1.67	21,959	FALSE			TRUE	The Workgroup recommen	October 2011	22	Complete	TRUE	Decrease
93662	Intracardiac echocardi	Cardiac Ablation Service	April 2021	07			ACC, HRS	2.53		High Volume Growth1 / High Vc	February 2008	ZZZ	0.00	0.00	NA	0.00	63,470	FALSE			FALSE					TRUE	Decrease
93668	Peripheral arterial dis	Peripheral Artery Disea	January 2018	28				New PE Inputs		CMS Request - Final Rule for 20	July 2017	XXX	0.00	0.40	NA	0.01	814	FALSE			FALSE					TRUE	PE Only
93701	Bioimpedance-derived	physiologic cardiovasc	February 2011	41				Remove from screen		Low Value-High Volume	October 2010	XXX	0.00	0.80	NA	0.01	14,268	FALSE			FALSE					TRUE	Remove from Screen
93731	Deleted from CPT	Cardiology Services	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008							FALSE			FALSE					TRUE	Deleted from CPT
93732	Deleted from CPT	Cardiology Services	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008							FALSE			FALSE					TRUE	Deleted from CPT
93733	Deleted from CPT	Cardiology Services	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008							FALSE			FALSE					TRUE	Deleted from CPT
93743	Deleted from CPT	Cardiology Services	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008							FALSE			FALSE					TRUE	Deleted from CPT
93744	Deleted from CPT	Cardiology Services	October 2008	26			ACC	Deleted from CPT		CMS Fastest Growing	October 2008							FALSE			FALSE					TRUE	Deleted from CPT
93750	Interrogation of ventr	Ventricular Assist Devic	April 2019	24			AATS, ACC	0.85		High Volume Growth5	October 2018	XXX	0.75	0.59	0.29	0.10	97,423	FALSE			FALSE					TRUE	Decrease
93792	Patient/caregiver trair	Home INR Monitoring	January 2020	37	January 2022	RAW		Reviewe in 2 years. 0.00 PE C		High Volume Growth3 / Work N	September 2016	XXX	0.00	1.90	NA	0.04	1,742	FALSE			FALSE		September 2016	08	yes	TRUE	PE Only
93793	Anticoagulant manage	Home INR Monitoring	January 2020	37	January 2022	RAW		Review in 2 years. 0.18		High Volume Growth3 / Work N	September 2016	XXX	0.18	0.14	NA	0.01	1,555,390	FALSE			FALSE		September 2016	08	yes	TRUE	Maintain
93875	Deleted from CPT	Noninvasive Vascular D	April 2010	45			AAN, ACC	Deleted from CPT		Codes Reported Together 75% c	February 2010							TRUE	SS in proce	Yes	TRUE	The Workgroup recommen	October 2010	43	Complete	TRUE	Deleted from CPT
93880	Duplex scan of extracr	Duplex Scans	April 2014	33			ACR, ACC,	0.80		Codes Reported Together 75% c	February 2010	XXX	0.80	4.97	NA	0.08	2,198,611	TRUE	Addressed	Yes	TRUE	The Workgroup recommen	October 2010	43	Complete	TRUE	Increase
93882	Duplex scan of extracr	Duplex Scans	April 2014	33			ACC, ACR,	0.50		CMS High Expenditure Procedur	January 2012	XXX	0.50	3.23	NA	0.08	33,564	FALSE			FALSE					TRUE	Increase

93886	Transcranial Doppler s	Duplex Scans	April 2014	33			AAN, ACC,	1.00		Codes Reported Together 75% c	February 2010	XXX	0.91	7.16	NA	0.07	104,495	FALSE			TRUE	The Workgroup recommen	October 2010	CCI edi	Complete	TRUE	Increase
93888	Transcranial Doppler s	Duplex Scans	April 2014	33			AAN, ACC,	0.70		Codes Reported Together 75% c	February 2010	XXX	0.50	4.34	NA	0.06	10,532	FALSE			TRUE	The Workgroup recommen	October 2010	CCI edi	Complete	TRUE	Increase
93890	Transcranial Doppler study of the intracranial		January 2020	37					Remove from Screen	High Volume Growth6	October 2019	XXX	1.00	7.28	NA	0.08	52,137	FALSE			FALSE					TRUE	Remove from Screen
93892	Transcranial Doppler study of the intracranial		January 2020	37					Remove from Screen	High Volume Growth6	October 2019	XXX	1.15	8.14	NA	0.09	55,222	FALSE			FALSE					TRUE	Remove from Screen
93922	Limited bilateral noni	Extremity Non-Invasive	April 2010	27			SVS, ACR,	0.25		CMS Fastest Growing	October 2008	XXX	0.25	2.20	NA	0.05	694,382	FALSE			TRUE	The Workgroup accepted t	February 2010	58	Revised	TRUE	Maintain
93923	Complete bilateral no	Extremity Non-Invasive	April 2010	27			SVS, ACR,	0.45		CMS Fastest Growing	February 2009	XXX	0.45	3.35	NA	0.07	440,595	FALSE			TRUE	The Workgroup accepted t	February 2010	58	Revised	TRUE	Maintain
93924	Noninvasive physiolog	Extremity Non-Invasive	April 2010	27			SVS, ACR,	0.50		CMS Fastest Growing	February 2009	XXX	0.50	4.23	NA	0.07	61,266	FALSE			TRUE	The Workgroup accepted t	February 2010	58	Revised	TRUE	Maintain
93925	Duplex scan of lower e	Duplex Scans	April 2014	33			ACC, ACR,	0.80		CMS-Other - Utilization over 50(	April 2011	XXX	0.80	6.56	NA	0.09	661,535	FALSE			FALSE					TRUE	Maintain
93926	Duplex scan of lower e	Duplex Scans	April 2014	33			ACC, ACR,	0.60		CMS-Other - Utilization over 50(	April 2011	XXX	0.50	3.82	NA	0.07	262,918	FALSE			FALSE					TRUE	Increase
93930	Duplex scan of upper e	Duplex Scans	April 2014	33			AAN, ACC,	0.80		CMS Request - Final Rule for 20	November 2013	XXX	0.80	5.12	NA	0.13	23,417	FALSE			FALSE					TRUE	Increase
93931	Duplex scan of upper e	Duplex Scans	April 2014	33			AAN, ACC,	0.50		Codes Reported Together 75% c	February 2010	XXX	0.50	3.21	NA	0.07	47,500	FALSE			TRUE	The Workgroup recommen	October 2010	CCI edi	Complete	TRUE	Increase
93965	Noninvasive physiolog	Non-invasive Physiologi	January 2016	47			ACC, ACR,	Deleted from CPT		CMS High Expenditure Procedur	July 2015							FALSE			TRUE	In January 2016, the specia	May 2016	28	Complete	TRUE	Deleted from CPT
93970	Duplex scan of extrem	Duplex Scans	April 2014	33			ACC, ACR,	0.70		CMS-Other - Utilization over 50(	April 2011	XXX	0.70	4.97	NA	0.07	1,626,806	FALSE			FALSE					TRUE	Maintain
93971	Duplex scan of extrem	Duplex Scans	April 2014	33			ACR, SVS,	0.45		Low Value-High Volume / CMS F	October 2010	XXX	0.45	3.11	NA	0.05	1,753,619	FALSE			FALSE					TRUE	Maintain
93975	Duplex scan of arteria	Duplex Scans	April 2014	33			ACR, SVS,	1.30		CMS Request - Final Rule for 20	November 2013	XXX	1.16	6.85	NA	0.13	218,302	FALSE			FALSE					TRUE	Decrease
93976	Duplex scan of arteria	Duplex Scans	April 2014	33			ACR	1.00		CMS Fastest Growing / CMS Rec	October 2008	XXX	0.80	3.95	NA	0.06	173,269	FALSE			FALSE					TRUE	Decrease
93978	Duplex scan of aorta, i	Duplex Scans	April 2014	33				0.97		CMS-Other - Utilization over 25(	April 2013	XXX	0.80	4.61	NA	0.12	287,616	FALSE			FALSE					TRUE	Increase
93979	Duplex scan of aorta, i	Duplex Scans	April 2014	33				0.70		CMS-Other - Utilization over 25(	October 2013	XXX	0.50	3.00	NA	0.07	66,512	FALSE			FALSE					TRUE	Increase
93982	Noninvasive physiolog	Endovascular Repair Pr	January 2017	10			SVS, SIR, S	Deleted from CPT		Codes Reported Together 75%o	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
93985	Duplex scan of arteria	Duplex Scan Arterial Inf	January 2019	17				0.80		CMS-Other - Utilization over 30,	October 2018	XXX	0.80	6.89	NA	0.15		FALSE			FALSE		September 2018	36		TRUE	Increase
93986	Duplex scan of arteria	Duplex Scan Arterial Inf	January 2019	17				0.50		CMS-Other - Utilization over 30,	October 2018	XXX	0.50	3.95	NA	0.08		FALSE			FALSE		September 2018	36		TRUE	Increase
93990	Duplex scan of hemod	Doppler Flow Testing	April 2014	40			ACR, SVS	0.60		CMS Fastest Growing / High Vol	October 2008	XXX	0.50	3.90	NA	0.11	132,133	FALSE			FALSE					TRUE	Increase
94010	Spirometry, including	Spirometry	October 2019	12			ATS, CHES	0.17		Low Value-High Volume	October 2010	XXX	0.17	0.67	NA	0.02	1,234,541	FALSE			FALSE					TRUE	Maintain
94014	Patient-initiated spiro	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove from screen - RUC a		High Volume Growth1	February 2008	XXX	0.52	1.07	NA	0.03	47	FALSE			FALSE					TRUE	Remove from Screen
94015	Patient-initiated spiro	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove from screen - RUC a		High Volume Growth1	February 2008	XXX	0.00	0.89	NA	0.01	38	FALSE			FALSE					TRUE	Remove from Screen
94016	Patient-initiated spiro	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove from screen - RUC a		High Volume Growth1	April 2008	XXX	0.52	0.18	0.18	0.02	5,244	FALSE			FALSE					TRUE	Remove from Screen
94060	Bronchodilation respo	Spirometry	October 2019	12			ATS, CHES	0.22		MPC List / CPT Assistant Analysi	October 2010	XXX	0.22	1.11	NA	0.02	1,160,195	TRUE	Mar 2014	Yes	FALSE					TRUE	Decrease
94200	Maximum breathing c	Lung Function Test	April 2018	28			ATS, CHES	0.05		CMS-Other - Utilization over 30,	October 2017	XXX	0.05	0.45	NA	0.02	74,436	FALSE			FALSE					TRUE	Decrease
94240	Deleted from CPT	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94250	Expired gas collection	RAW	October 2019	17				Deleted from CPT		CMS-Other - Utilization over 20,	January 2019						20,825	FALSE			FALSE					TRUE	Deleted from CPT
94260	Deleted from CPT	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94350	Deleted from CPT	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94360	Deleted from CPT	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94370	Determination of airw	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94400	Breathing response to	Evaluation of Wheezing	April 2019	25			ATS, CHES	Deleted from CPT		Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018							1,310	TRUE	Mar 2014	Yes	TRUE	In January 2019, the RUC re	September 2019	49	yes	TRUE	Deleted from CPT
94450	Breathing response to	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove from screen - RUC a		High Volume Growth1	February 2008	XXX	0.40	1.35	NA	0.04	56	FALSE			FALSE					TRUE	Remove from Screen
94617	Exercise test for bron	Pulmonary Diagnostic T	October 2016	05			ATS, CHES	0.70		CMS High Expenditure Procedur	February 2016	XXX	0.70	1.98	NA	0.06	9,892	FALSE			FALSE		February 2016	39	Complete	TRUE	Decrease
94618	Pulmonary stress testi	Pulmonary Diagnostic T	October 2016	05			ATS, CHES	0.48		CMS High Expenditure Procedur	February 2016	XXX	0.48	0.46	NA	0.03	271,019	FALSE			FALSE		February 2016	39	Complete	TRUE	Decrease
94620	Pulmonary stress testi	Pulmonary Diagnostic T	October 2016	05			ATS, CHES	Deleted from CPT		CMS High Expenditure Procedur	July 2015							FALSE			TRUE	In January 2016, the specia	February 2016	39	Complete	TRUE	Deleted from CPT
94621	Cardiopulmonary exer	Pulmonary Diagnostic T	October 2016	05			ATS, CHES	1.42		CMS High Expenditure Procedur	January 2016	XXX	1.42	3.07	NA	0.10	21,378	FALSE			TRUE	In January 2016, the specia	February 2016	39	Complete	TRUE	Maintain
94640	Pressurized or nonpre	Evaluation of Wheezing	April 2019	25			AAFP, ATS	New PE Inputs		Codes Reported Together 75% or More-Part2 /CPT		XXX	0.00	0.40	NA	0.01	601,038	TRUE	Mar 2014	Yes	FALSE					TRUE	PE Only
94667	Manipulation chest wa	Evaluation of Wheezing	April 2019	25			ATS, CHES	New PE Inputs		CPT Assistant Analysis 2018	April 2019	XXX	0.00	0.61	NA	0.01	6,331	FALSE			FALSE					TRUE	PE Only
94668	Manipulation chest wa	Evaluation of Wheezing	April 2019	25			AAFP, ATS	New PE Inputs CPT Assistant		Codes Reported Together 75% or More-Part2 / CPT		XXX	0.00	0.94	NA	0.02	5,171	TRUE	Mar 2014	Yes	FALSE					TRUE	PE Only
94669	Mechanical chest wall	Evaluation of Wheezing	April 2019	25			ATS, CHES	New PE Inputs		CPT Assistant Analysis 2018	April 2019	XXX	0.00	0.65	NA	0.02	324	FALSE			FALSE					TRUE	PE Only
94681	Oxygen uptake, expire	Pulmonary Tests	September 2011	51			AACE, TES	Remove from screen		High Volume Growth1 / CMS Fa	February 2008	XXX	0.20	1.27	NA	0.02	7,816	FALSE			FALSE					TRUE	Remove from Screen
94720	Carbon monoxide diff	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94725	Membrane diffusion c	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted from CPT		Codes Reported Together 75% c	February 2010							FALSE			TRUE	The RUC accepted the spec	October 2010	44	Complete	TRUE	Deleted from CPT
94726	Plethysmography for c	Pulmonary Function Te	April 2011	19			ACCP, ATS	0.31		Codes Reported Together 75% c	February 2010	XXX	0.26	1.30	NA	0.03	681,512	FALSE			FALSE		February 2011			TRUE	Decrease
94727	Gas dilution or washo	Pulmonary Function Te	April 2011	19			ACCP, ATS	0.31		Codes Reported Together 75% c	February 2010	XXX	0.26	1.00	NA	0.02	348,523	FALSE			FALSE		February 2011			TRUE	Decrease
94728	Airway resistance by c	Pulmonary Function Te	April 2011	19			ACCP, ATS	0.31		Codes Reported Together 75% c	February 2010	XXX	0.26	0.91	NA	0.02	4,985	FALSE			FALSE		February 2011			TRUE	Decrease
94729	Diffusing capacity (eg,	Pulmonary Function Te	April 2011	19			ACCP, ATS	0.19		Codes Reported Together 75% c	February 2010	ZZZ	0.19	1.52	NA	0.02	1,113,315	FALSE			FALSE		February 2011			TRUE	Decrease
94750	Pulmonary compliance	RAW	October 2019	17				Deleted from CPT		CMS-Other - Utilization over 20,	January 2019						18,981	FALSE			FALSE					TRUE	Deleted from CPT
94760	Noninvasive ear or pu	Measure Blood Oxygen	February 2009	32			ACCP, ATS	New PE inputs		CMS Request - Practice Expense	NA	XXX	0.00	0.06	NA	0.01	29,834	FALSE			FALSE					TRUE	PE Only
94761	Noninvasive ear or pu	Measure Blood Oxygen	February 2009	32			ACCP, ATS	New PE inputs		CMS Request - Practice Expense	NA	XXX	0.00	0.10	NA	0.01	16,501	FALSE			FALSE					TRUE	PE Only
94762	Noninvasive ear or pu	Measure Blood Oxygen	February 2009	32			ACCP, ATS	New PE inputs		CMS Fastest Growing, CMS Requ	October 2008	XXX	0.00	0.78	NA	0.01	208,171	FALSE			FALSE					TRUE	PE Only
94770	Carbon dioxide, expire	Evaluation of Wheezing	April 2019	25			ATS, CHES	Deleted from CPT		High Volume Growth1 / Codes F	February 2008						5,724	TRUE	Mar 2014	Yes	TRUE	In April 2019, when review	September 2019	49	yes	TRUE	Deleted from CPT
95004	Percutaneous tests (sc	Percutaneous Allergy Te	October 2016	27		RUC	AAAAI, AA	0.01		Low Value-Billed in Multiple Un	October 2010	XXX	0.01	0.10	NA	0.01	10,738,966	FALSE			FALSE					TRUE	Maintain
95010	Percutaneous tests (sc	Percutaneous Allergy Te	April 2011	31			JCAAI, ACA	Deleted from CPT		Low Value-Billed in Multiple Un	October 2010							FALSE			TRUE	The specialty societies indi	February 2012	15	Complete	TRUE	Deleted from CPT
95012	Nitric oxide expired ga	Exhaled Nitric Oxide Me	April 2019	26			AAAAI, AC	New PE Inputs		High Volume Growth5	October 2018	XXX	0.00	0.57	NA	0.01	136,728	FALSE			FALSE					TRUE	PE Only
95015	Intracutaneous (intrac	Intracutaneous Allgery	April 2011	31			JCAAI, ACA	Deleted from CPT		Low Value-Billed in Multiple Un	October 2010							FALSE			TRUE	The specialty societies indi	February 2012	15	Complete	TRUE	Deleted from CPT
95017	Allergy testing, any co	Percutaneous Allergy Te	April 2012	29			JCAAI	0.07		Low Value-Billed in Multiple Un	October 2010	XXX	0.07	0.17	0.03	0.01	27,662	FALSE			TRUE	Deleted codes 95010 and 9	February 2012	15	Complete	TRUE	Decrease
95018	Allergy testing, any co	Percutaneous Allergy Te	April 2012	29			JCAAI	0.14		Low Value-Billed in Multiple Un	October 2010	XXX	0.14	0.47	0.06	0.01	129,391	FALSE			TRUE	Deleted codes 95010 and 9	February 2012	15	Complete	TRUE	Decrease
95024	Intracutaneous (intrac	Intracutaneous Allgery	October 2017	19			JCAAI, ACA	New PE Inputs.		Low Value-Billed in Multiple Un	October 2010	XXX	0.01	0.23	0.01	0.01	1,833,929	FALSE			FALSE					TRUE	PE Only
95027	Intracutaneous (intrac	Intracutaneous Allgery	February 2011	41			JCAAI, ACA	0.01		Low Value-Billed in Multiple Un	October 2010	XXX	0.01	0.12	NA	0.01	164,524	FALSE			FALSE					TRUE	Maintain
95115	Professional services f	Immunotherapy Injectio	April 2012	48			JCAAI, AAC	New PE Inputs		CMS High Expenditure Procedur	January 2012	XXX	0.00	0.26	NA	0.01	1,034,318	FALSE			FALSE					TRUE	PE Only
95117	Professional services f	Immunotherapy Injectio	April 2012	48			JCAAI, AAC	New PE Inputs		CMS High Expenditure Procedur	September 2011	XXX	0.00	0.32	NA	0.01	2,769,382	FALSE			FALSE					TRUE	PE Only
95144	Professional services f	Antigen Therapy Service	January 2016	49			AAOHNS, A	0.06		Low Value-Billed in Multiple Un	October 2010	XXX	0.06	0.41	0.02	0.01	178,622	FALSE			FALSE					TRUE	Maintain
95148	Professional services for the supervision of pr		October 2010	73				0.06		Low Value-Billed in Multiple Un	October 2010	XXX	0.06	2.59	0.02	0.01	20,261	FALSE			FALSE					TRUE	Maintain
95165	Professional services f	Antigen Therapy Service	January 2016	49			AAOHNS, A	0.06		MPC List / CMS High Expenditur	October 2010	XXX	0.06	0.39	0.02	0.01	7,687,749	FALSE			FALSE					TRUE	Maintain
95249	Ambulatory continuou	Continuous Glucose Mo	April 2017	08			AACE, ES, A	PE Only. Referral to CPT Assis		High Volume Growth2		XXX	0.00	1.64	NA	0.04	10,730	TRUE	June 2018	yes	TRUE	The RUC recommends refe	June 2017	EC	yes	TRUE	PE Only
95250	Ambulatory continuou	Continuous Glucose Mo	January 2020	37	January 2023	RAW	AACE, ES	Re-review at RAW. New PE i		High Volume Growth2 / Work N	October 2013	XXX	0.00	4.47	NA	0.04	76,885	FALSE			TRUE	In May 2014, the CPT Edito	October 2015 & Fe	38	yes	TRUE	PE Only
95251	Ambulatory continuou	Continuous Glucose Mo	January 2020	37	January 2023	RAW	AACE, ES	Re-review at RAW. 0.70.		High Volume Growth / Work Ne	April 2013	XXX	0.70	0.28	0.28	0.04	248,288	FALSE			TRUE	In October 2016, at the Pra	February 2017	38	yes	TRUE	Decrease
95700	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95705	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95706	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95707	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95708	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95709	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95710	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95711	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95712	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95713	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95714	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95715	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95716	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	PE Only		High Volume Growth4	May 2018	XXX	0.00	0.00	0.00	0.00		FALSE			FALSE					TRUE	PE Only
95717	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	2.00		High Volume Growth4	May 2018	XXX	2.00	0.82	0.79	0.14		FALSE			FALSE					TRUE	Decrease
95718	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	2.50		High Volume Growth4	May 2018	XXX	2.50	1.25	1.18	0.20		FALSE			FALSE					TRUE	Decrease
95719	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	3.00		High Volume Growth4	May 2018	XXX	3.00	1.37	1.32	0.21		FALSE			FALSE					TRUE	Decrease
95720	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	3.86		High Volume Growth4	May 2018	XXX	3.86	1.91	1.82	0.28		FALSE			FALSE					TRUE	Decrease
95721	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	3.86		High Volume Growth4	May 2018	XXX	3.86	1.95	1.83	0.28		FALSE			FALSE					TRUE	Decrease
95722	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	4.70		High Volume Growth4	May 2018	XXX	4.70	2.36	2.22	0.36		FALSE			FALSE					TRUE	Decrease
95723	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	4.75		High Volume Growth4	May 2018	XXX	4.75	2.45	2.28	0.37		FALSE			FALSE					TRUE	Decrease
95724	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	6.00		High Volume Growth4	May 2018	XXX	6.00	3.02	2.84	0.45		FALSE			FALSE					TRUE	Decrease
95725	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	5.40		High Volume Growth4	May 2018	XXX	5.40	2.82	2.61	0.43		FALSE			FALSE					TRUE	Decrease
95726	Electroencephalogran	Long-Term EEG Monito	October 2018	13			AAN, ACN	7.58		High Volume Growth4	May 2018	XXX	7.58	3.83	3.59	0.59		FALSE			FALSE					TRUE	Decrease
95800	Sleep study, unattend	Sleep Testing	April 2010	28			ACNS, AAN	1.05		CMS Fastest Growing	October 2009	XXX	0.85	3.98	NA	0.05	24,715	FALSE			FALSE		October 2009			TRUE	Decrease
95801	Sleep study, unattend	Sleep Testing	April 2010	28			ACNS, AAN	1.00		CMS Fastest Growing	October 2009	XXX	0.85	1.72	NA	0.05	422	FALSE			FALSE		October 2009			TRUE	Decrease

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G0452	Molecular pathology p	Molecular Pathology In	October 2019	13			0.93	CMS-Other - Utilization over 30,	October 2018	XXX	0.93	0.44	NA	0.05	128,942	FALSE		FALSE					TRUE	Increase
G0453	Continuous intraopera	RAW	October 2016	35			Remove from screen	CMS-Other - Utilization over 10(	April 2016	XXX	0.60	NA	0.30	0.05	402,739	FALSE		FALSE					TRUE	Remove from screen
G0456	Negative pressure wo	Negative Pressure Wou	January 2014	17			RUC recommended to survey	CMS Request - Final Rule for 20	November 2012							FALSE		TRUE	In January 2013, the RAW r	May 2013	28	Complete	TRUE	Deleted from CPT
G0457	Negative pressure wo	Negative Pressure Wou	January 2014	17			RUC recommended to survey	CMS Request - Final Rule for 20	November 2012							FALSE		TRUE	In January 2013, the RAW r	May 2013	28	complete	TRUE	Deleted from CPT
G0500	Moderate sedation services provided by the s		January 2021	29			Maintain	CMS-Other - Utilization over 20,	October 2020	XXX	0.10	1.57	0.04	0.02	490,072	FALSE		FALSE					TRUE	Remove from screen
G0506	Comprehensive assessment of and care plann		January 2021	29	October 2021	RAW	Review action plan	CMS-Other - Utilization over 20,	October 2020	ZZZ	0.87	0.85	0.37	0.05	119,106	FALSE		FALSE					FALSE	
G6001	Ultrasonic guidance for placement of radiatio		January 2021	29	January 2022	RUC	AADA, AST	Refer to CPT	CMS-Other - Utilization over 20,	October 2020	XXX	0.58	3.88	NA	0.03	124,968	FALSE		TRUE	The RUC identified G6001 \	September 2021			FALSE	
G6002	Stereoscopic x-ray guidance for localization of		January 2018	31			Remove from screen	CMS-Other - Utilization over 30,	October 2017	XXX	0.39	1.80	NA	0.02	1,291,326	FALSE		FALSE					TRUE	Remove from screen
G6012	Radiation treatment delivery,3 or more separ		January 2021	29	October 2023	RAW	Review action plan	CMS-Other - Utilization over 20,	October 2020	XXX	0.00	7.57	NA	0.02	357,383	FALSE		FALSE					FALSE	
G6013	Radiation treatment delivery,3 or more separ		January 2021	29	October 2023	RAW	Review action plan	CMS-Other - Utilization over 20,	October 2020	XXX	0.00	7.59	NA	0.02	218,027	FALSE		FALSE					FALSE	
G6014	Radiation treatment d	RAW	October 2019	17			Remove from screen	CMS-Other - Utilization over 20,	January 2019	XXX	0.00	7.57	NA	0.02	22,014	FALSE		FALSE					TRUE	Remove from Screen
G6015	Intensity modulated treatment delivery, singl		January 2021	29	October 2023	RAW	Review action plan	CMS-Other - Utilization over 20,	October 2020	XXX	0.00	11.01	NA	0.04	1,297,349	FALSE		FALSE					FALSE	
G6017	Intra-fraction localization and tracking of targ		January 2021	29	October 2023	RAW	Review action plan	CMS-Other - Utilization over 20,	October 2020	YYY	0.00	0.00	0.00	0.00	86,769	FALSE		FALSE					FALSE	
G2211	Visit complexity inher	Visit Complexity E/M A	January 2020	34			No recommendation on phys	CMS Request - Final Rule for 20	November 2019							FALSE		FALSE					TRUE	N/A
P3001	Screening papanicolac	Cytopathology Cervical/	April 2018	26		CAP	0.42	CMS-Other - Utilization over 30,	October 2017	XXX	0.26	0.36	0.36	0.01	1,599	FALSE		FALSE					TRUE	Maintain
Q0091	Screening papanicolac	RAW	January 2019	37		No Special	RUC recommended to survey	CMS-Other - Utilization over 30,	October 2018	XXX	0.37	0.85	0.14	0.04	533,729	FALSE		FALSE					TRUE	Maintain

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37220	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37221	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37222	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37223	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37224	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37225	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37226	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37227	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37228	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37229	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37230	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37231	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37232	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37233	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37234	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37235	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50080	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	September 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50081	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	September 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
63030	**Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**	Pre-Time Analysis / Site of Service Anomaly - 2018	January 2021	AANS, AAOS, NASS	September 2021

Background: CPT code 63030 was identified via the site of service anomaly screent. In December 2020, the Relativity Assessment Workgroup noted that CPT code 63030 continues to be primarily reported in the outpatient setting yet still includes inpatient hospital visits. The specialty society indicated that there is still confusion, and 63030 is inappropriately being reporting in the outpatient setting. The RUC recommends that CPT code 63030 be referred to CPT (May 2021) to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The RUC understands that this service will be surveyed after the CPT revisions and reviewed by the RUC.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76998	**Ultrasonic guidance, intraoperative**	CMS-Other - Utilization over 20,000 Part1	October 2019	STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS	September 2021

Background: In October 2018, the Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000. In October 2019, the RUC refers this issued to CPT Editorial Panel (May 2020) to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99415	**Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	September 2021, February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99416	**Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for outpatient Evaluation and Management service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	September 2021, February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G0396	**Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**	CMS-Other - Utilization over 30,000	January 2018	AAFP, ASA, ASAM	Time Uncertain

Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel said that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined, and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel's additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G6001	**Ultrasonic guidance for placement of radiation therapy fields**	CMS-Other - Utilization over 20,000 Part2	January 2021	AADA, ASTRO	September 2021

Background: The RUC identified G6001 via the CMS/Other Source Utilization over 20,000 screen. In January 2021, the RUC recommended to refer to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology).

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
63685	**Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**	Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7	January 2021	Review action plan in 2 years after CPT article published. 6.05	AAPM, AANS/CNS, ASA, ISIS, NASS	

Background: Oct 2010 re-reviewed site of service issue. In October 2020, the RUC identified six codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2014 through 2019e. CPT codes 00918, 63685, 75561, 75572, 75574 and 93655. The Workgroup requested that the specialty societies submit an action plan for codes CPT codes 00918, 63685, 75561, 75572, 75574 and 93655 for January 2021. In January 2021, the RUC recommended to refer to CPT Assistant. A CPT Assistant article has already been submitted. The RUC will reeview after 2 years of data are available after article is published.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
75710	**Angiography, extremity, unilateral, radiological supervision and interpretation**	CMS High Expenditure Procedural Codes2	January 2021	Refer to CPT Assistant and review after 2 years of data after publication available. 1.75	ACR, ACC, RPA, SCAI, SIR, SVS	July 2021

Background: In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In October 2016 the RUC noted that with the newly bundled dialysis access maintenance codes that were approved in January 2016 as part of Dialysis Circuit code family 36901-36909, the specialties project that a significant portion of the nephrology volume for 75710 will instead be reported with applicable Dialysis Circuit codes. Nephrology represented 17.8 percent of the 2015 Medicare claims for 75710. The RUC will add a flag for review to confirm that nephrology utilization volume has decreased once 2017 Medicare utilization data is available for review. The RUC noted the nephrology utilization is slightly decreasing. The RUC recommended to review utilization again in 2 years (Oct 2020). In October 2020, the Workgroup reviewed the history of this code and the action plan submitted by SVS, SIR, ACR and ACC. Noting that the 2019e utilization by nephrologists was gradually decreasing (13%) (global & -26 modifier). The Workgroup questioned if the gradual decrease in utilization by nephrologists is appropriate or if nephrologists should not be performing this service at all. The Workgroup noted that RPA was not involved in the development of this action plan. The Workgroup requested the input from Nephrology regarding the reporting of CPT code 75710 and review at the January 2021 meeting. In January 2021, the Relativity Assessment Workgroup noted that the utilization of nephrology continues to decrease but not at the rate the specialty societies thought it would. The specialty societies indicated that they would submit a CPT Assistant article to address the appropriate reporting of this service. The Workgroup recommends that this service be referred to CPT Assistant and reviewed after 2 years of data is available after the publication of the article. The specialty societies noted that the expected utilization for Nephrology would be under 10%.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
G0407	**Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth**	CMS-Other - Utilization over 20,000 Part2	April 2021	Review action plan	AAN, ANA, APA (psychiatry)	

Background: In October 2020, the RUC identified 11 codes with 2019 estimated Medicare utilization over 20,000. Codes G0407, G0408, G0422, G0423, G0500, G0506, G6001, G6012, G6013, G6015 and G6017. The Workgroup requests that action plans be reviewed for these services at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed. At the December 2020 RAW meeting, the Workgroup recommended to postpone until April 2021 RAW for input from ANA and APA. In April 2021, the RUC the recommended these services be reviewed in 2 years (April 2023) after additional data are available. Second, there should be a CPT Assistant article, if appropriate, or other CMS education regarding who should be reporting these services. The RAW also would like to inform CMS of possible misreporting of these services. Based on the Medicare Provider Utilization and Payment Data Physician and Other Supplier PUF CY 2018 data, seven to eight individual Nurse Practitioners account for approximately 50% of G0407 and G0408 services provided.

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
G0408	**Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth**	CMS-Other - Utilization over 20,000 Part2	April 2021	Review action plan	AAN, ANA, APA (psychiatry)	

Background: In October 2020, the RUC identified 11 codes with 2019 estimated Medicare utilization over 20,000. Codes G0407, G0408, G0422, G0423, G0500, G0506, G6001, G6012, G6013, G6015 and G6017. The Workgroup requests that action plans be reviewed for these services at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed. At the December 2020 RAW meeting, the Workgroup recommended to postpone until April 2021 RAW for input from ANA and APA. In April 2021, the RUC the recommended these services be reviewed in 2 years (April 2023) after additional data are available. Second, there should be a CPT Assistant article, if appropriate, or other CMS education regarding who should be reporting these services. The RAW also would like to inform CMS of possible misreporting of these services. Based on the Medicare Provider Utilization and Payment Data Physician and Other Supplier PUF CY 2018 data, seven to eight individual Nurse Practitioners account for approximately 50% of G0407 and G0408 services provided.

Physician Time from RUC Meeting:
April 2021 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
22630	40	20	15	150	30			2	1		1	2		1				479
22632				60														60
22633	40	20	15	180	30			2	1		1	2		1				509
22634				65														65
22869	33	12	10	45	17		1	1						0.5				175
22870				45														45
27446	40	15	15	90	45			2	1					0.5				310
27447	40	15	15	97	20			3				2		1				374
43235	14	3	5	15	12													49
69714	33	3	10	40	15		1	2						0.5				182
69717	33	3	10	45	15		1	2						0.5				187
90460				7														7
90461				5														5
90471				7														7
90472				7														7
90473				7														7
90474				7														7
92065	2			30	4													36
92284	1			3	1													5
92287	1			10	1													12
93613				90														90
93621				20														20
93653	31	3	15	120	30													199
93654	40	3	15	200	33													291
93655				60														60
93656	35	3	15	180	30													263
93657				60														60
93662				25														25
99281				10														10
99282				18														18
99283				30														30
99284				40														40
99285				60														60
99304	6			25	5													36
99305	10			35	10													55
99306	15			50	15													80
99307	1			12	1													14
99308	5			18	4													27
99309	7			30	10													47
99310	10			45	15													70
99483	11			60	15													86
0041A				7														7
0042A				7														7
15778	40	3	15	90	25							1						213

Physician Time from RUC Meeting:
April 2021 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
42975	18	1	6	15	10													50
43290	18	3	5	30	20													76
43291	18	3	5	30	15													71
49591	25	3	15	45	20													108
49592	35	3	15	60	30													143
49593	30	10	15	90	30													175
49594	35	15	15	120	40													225
49595	40	15	15	120	40													230
49596	40	15	15	160	25								1					310
49613	30	10	15	60	20													135
49614	35	10	15	75	30													165
49615	35	10	15	100	30													190
49616	40	15	15	140	25							1						275
49617	40	15	15	150	28							1						288
49618	40	15	15	180	30								1					335
49621	40	15	15	120	25						1							235
49622	40	15	15	150	25							1						285
49623				45														45
63053				40														40
63052				45														45
69716	32	3	10	60	15			2						0.5				185
69719	33	3	10	60	15			2						0.5				186
69726	32	3	10	30	15		1	1						0.5				148
69727	33	3	10	45	15		1	1						0.5				164
96202	2			10	3													15
96203				3														3
G0008				7														7
G0009				7														7
G0010				7														7

Detailed Description of Pre-Service Time Packages (Minutes)

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

**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

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

Additional Positioning Times for Spinal Surgical Procedures

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

Additional Positioning Times for Spinal Injection Procedures

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

Additional Positioning Times for Urological Procedures

U1	Dorsal Lithotomy	5 Minutes

Notes:

- Roll-over cells for additional detail where available
- Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

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

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

1 This represents a simple dressing

CPT	RUC Recommended PLI Crosswalk
22630	22630
22632	22632
22633	22633
22634	22634
22869	22869
22870	22870
27446	27446
27447	27447
43235	43235
69714	69714
69717	69717
90460	90460
90461	90461
90471	90471
90472	90472
90473	90473
90474	90474
92065	92065
92284	92284
92287	92287
93613	93613
93621	93621
93653	93653
93654	93654
93655	93655
93656	93656
93657	93657
93662	93662
99281	99281
99282	99282
99283	99283
99284	99284
99285	99285
99304	99304
99305	99305
99306	99306
99307	99307
99308	99308
99309	99309
99310	99310
99415	99415

99416	99416
99483	99483
0041A	90460
0042A	90460
15778	11008
42975	31573
43290	43215
43291	43215
49591	11008
49592	11008
49593	11008
49594	11008
49595	11008
49596	11008
49613	11008
49614	11008
49615	11008
49616	11008
49617	11008
49618	11008
49621	11008
49622	11008
49623	11008
63053	63066
63052	63066
69716	31070
69719	31070
69726	31070
69727	31070
92066	92065
96202	G0109
96203	G0109
G0008	G0008
G0009	G0009
G0010	G0010

CPT	BETOS Class	BETOS Subclass	BETOS Subclass2
22630	Procedures	Major procedure	Explor/Decompr/Excis disc
22632	Procedures	Major procedure	Explor/Decompr/Excis disc
22633	Procedures	Major procedure	Explor/Decompr/Excis disc
22634	Procedures	Major procedure	Explor/Decompr/Excis disc
22869	Procedures	Major procedure	Other
22870	Procedures	Major procedure	Other
27446	Procedures	Major procedure	Orthopedic - Knee replacement
27447	Procedures	Major procedure	Orthopedic - Knee replacement
43235	Procedures	Endoscopy	Upper Gastrointestinal
69714	Procedures	Major procedure	Other
69717	Procedures	Major procedure	Other
90460	Other	Immunizations/Vaccinations	NA
90461	Other	Immunizations/Vaccinations	NA
90471	Other	Immunizations/Vaccinations	NA
90472	Other	Immunizations/Vaccinations	NA
90473	Other	Immunizations/Vaccinations	NA
90474	Other	Immunizations/Vaccinations	NA
92065	Procedures	Eye procedure	Other
92284	Tests	Other tests	Other
92287	Imaging	Other	NA
93613	Imaging	Imaging/procedure	Heart inc. Cardiac Catheter
93621	Procedures	Major procedure	Cardiovascular-Other
93653	Procedures	Major procedure	Cardiovascular-Other
93654	Procedures	Major procedure	Cardiovascular-Other
93655	Procedures	Major procedure	Cardiovascular-Other
93656	Procedures	Major procedure	Cardiovascular-Other
93657	Procedures	Major procedure	Cardiovascular-Other
93662	Imaging	Imaging/procedure	Heart inc. Cardiac Catheter
99281	Evaluation Management	Emergency room visit	NA
99282	Evaluation Management	Emergency room visit	NA
99283	Evaluation Management	Emergency room visit	NA
99284	Evaluation Management	Emergency room visit	NA
99285	Evaluation Management	Emergency room visit	NA
99304	Evaluation Management	Nursing home visit	NA
99305	Evaluation Management	Nursing home visit	NA
99306	Evaluation Management	Nursing home visit	NA
99307	Evaluation Management	Nursing home visit	NA
99308	Evaluation Management	Nursing home visit	NA
99309	Evaluation Management	Nursing home visit	NA
99310	Evaluation Management	Nursing home visit	NA
99415	Evaluation Management	NA	NA
99416	Evaluation Management	NA	NA
99483	Evaluation Management	NA	NA
0041A	Other	Immunizations/Vaccinations	NA
0042A	Other	Immunizations/Vaccinations	NA
15778	Procedures	NA	Other
42975	Procedures	Endoscopy	Other

43290	Procedures	Endoscopy	Upper Gastrointestinal
43291	Procedures	Endoscopy	Upper Gastrointestinal
49591	Procedures	Major procedure	Other
49592	Procedures	Major procedure	Other
49593	Procedures	Major procedure	Other
49594	Procedures	Major procedure	Other
49595	Procedures	Major procedure	Other
49596	Procedures	Major procedure	Other
49613	Procedures	Major procedure	Other
49614	Procedures	Major procedure	Other
49615	Procedures	Major procedure	Other
49616	Procedures	Major procedure	Other
49617	Procedures	Major procedure	Other
49618	Procedures	Major procedure	Other
49621	Procedures	Major procedure	Other
49622	Procedures	Major procedure	Other
49623	Procedures	Major procedure	Other
63052	Procedures	Major procedure	Explor/Decompr/Excis disc
63051	Procedures	Major procedure	Explor/Decompr/Excis disc
69716	Procedures	Major procedure	Other
69719	Procedures	Major procedure	Other
69726	Procedures	Major procedure	Other
69727	Procedures	Major procedure	Other
92066	Procedures	Eye procedure	Other
96202	Evaluation Management	Specialist	Psychiatry
96203	Evaluation Management	Specialist	Psychiatry
G0008	Other	Immunizations/Vaccinations	NA
G0009	Other	Immunizations/Vaccinations	NA
G0010	Other	Immunizations/Vaccinations	NA

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
22630		5,654	22630	5,654	1.000	22.09	22.09	04 Arthrodesis Decompression	124,897	124,897
22632		1,875	22632	1,875	1.000	5.22	5.22	04 Arthrodesis Decompression	9,788	9,788
22633		38,096	22633	38,096	1.000	27.75	26.80	04 Arthrodesis Decompression	1,020,973	1,057,164
22634		14,338	22634	14,338	1.000	8.16	7.96	04 Arthrodesis Decompression	114,130	116,998
63047		101,838	63052	11,000	0.108	7.69	5.70	04 Arthrodesis Decompression	62,700	84,535
63047		101,838	63047	90,838	0.892	7.69	7.69	04 Arthrodesis Decompression	698,090	698,090
63048		128,927	63053	4,000	0.031	3.47	5.00	04 Arthrodesis Decompression	20,000	13,880
63048		128,927	63048	124,927	0.969	3.47	3.47	04 Arthrodesis Decompression	433,497	433,497
31599		301	42975	100	0.332	0.00	1.95	05 Drug Induced Sleep Endoscopy	195	0
31599		301	31599	201	0.668	0.00	0.00	05 Drug Induced Sleep Endoscopy	0	0
93653		31,821	93653	31,821	1.000	14.75	15.00	07 Cardiac Ablation	477,315	469,360
93613		80,773	Util Savings (Bundled into 93653)	27,172	0.336	5.23	0.00	07 Cardiac Ablation	0	142,110
93621		29,892	Util Savings (Bundled into 93653)	23,134	0.774	2.10	0.00	07 Cardiac Ablation	0	48,581
93654		7,750	93654	7,750	1.000	19.75	18.10	07 Cardiac Ablation	140,275	153,063
93655		31,147	93655	31,147	1.000	7.50	7.00	07 Cardiac Ablation	218,029	233,603
93656		53,327	93656	53,327	1.000	19.77	17.00	07 Cardiac Ablation	906,559	1,054,275
93613		80,773	Util Savings (Bundled into 93656)	49,327	0.611	5.23	0.00	07 Cardiac Ablation	0	257,980
93662		63,470	Util Savings (Bundled into 93656)	48,277	0.761	2.80	0.00	07 Cardiac Ablation	0	135,176
93657		21,159	93657	21,159	1.000	7.50	7.00	07 Cardiac Ablation	148,113	158,693
93613		80,773	93613	4,274	0.053	5.23	5.23	07 Cardiac Ablation	22,353	22,353
93621		29,892	93621	6,758	0.226	2.10	1.75	07 Cardiac Ablation	11,827	14,192
93662		63,470	93662	15,193	0.239	1.44	2.53	07 Cardiac Ablation	38,438	21,878
43235		323,621	43235	323,621	1.000	2.09	2.09	08 Endoscopic Bariatric Device Procedures	676,368	676,368
43999		7,587	43290	2,523	0.333	0.00	3.11	08 Endoscopic Bariatric Device Procedures	7,847	0
43999		7,587	43999	5,064	0.667	0.00	0.00	08 Endoscopic Bariatric Device Procedures	0	0
43247		28,637	43291	2,523	0.088	3.11	2.80	08 Endoscopic Bariatric Device Procedures	7,064	7,847
49560	D	22,089	49591	14,358	0.650	11.92	6.27	09 Anterior Abdominal Hernia Repair	90,024	171,146
49654	D	7,253	49591	2,901	0.400	13.76	6.27	09 Anterior Abdominal Hernia Repair	18,191	39,921
49570	D	616	49591	610	0.990	6.05	6.27	09 Anterior Abdominal Hernia Repair	3,824	3,690
49585	D	18,847	49591	17,905	0.950	6.59	6.27	09 Anterior Abdominal Hernia Repair	112,262	117,992
49652	D	9,327	49591	7,462	0.800	11.92	6.27	09 Anterior Abdominal Hernia Repair	46,784	88,942
49590	D	714	49591	393	0.550	8.90	6.27	09 Anterior Abdominal Hernia Repair	2,462	3,495
49560	D	22,089	49593	6,627	0.300	11.92	10.80	09 Anterior Abdominal Hernia Repair	71,568	78,990
49654	D	7,253	49593	3,627	0.500	13.76	10.80	09 Anterior Abdominal Hernia Repair	39,166	49,901
49570	D	616	49593	6	0.010	6.05	10.80	09 Anterior Abdominal Hernia Repair	67	37
49585	D	18,847	49593	754	0.040	6.59	10.80	09 Anterior Abdominal Hernia Repair	8,142	4,968
49652	D	9,327	49593	1,399	0.150	11.92	10.80	09 Anterior Abdominal Hernia Repair	15,110	16,677
49590	D	714	49593	250	0.350	8.90	10.80	09 Anterior Abdominal Hernia Repair	2,699	2,224
49560	D	22,089	49595	884	0.040	11.92	14.88	09 Anterior Abdominal Hernia Repair	13,147	10,532
49654	D	7,253	49595	653	0.090	13.76	14.88	09 Anterior Abdominal Hernia Repair	9,713	8,982
49585	D	18,847	49595	188	0.010	6.59	14.88	09 Anterior Abdominal Hernia Repair	2,804	1,242
49652	D	9,327	49595	466	0.050	11.92	14.88	09 Anterior Abdominal Hernia Repair	6,939	5,559
49590	D	714	49595	-	0.000	8.90	14.88	09 Anterior Abdominal Hernia Repair	0	0
49590	D	714	49592	36	0.050	8.90	9.00	09 Anterior Abdominal Hernia Repair	321	318
49561	D	12,726	49592	8,272	0.650	15.38	9.00	09 Anterior Abdominal Hernia Repair	74,447	127,222
49655	D	4,804	49592	3,123	0.650	16.84	9.00	09 Anterior Abdominal Hernia Repair	28,103	52,585
49572	D	451	49592	446	0.990	7.87	9.00	09 Anterior Abdominal Hernia Repair	4,018	3,514
49587	D	7,947	49592	6,755	0.850	7.08	9.00	09 Anterior Abdominal Hernia Repair	60,795	47,825
49653	D	5,848	49592	4,971	0.850	14.94	9.00	09 Anterior Abdominal Hernia Repair	44,737	74,264
49590	D	714	49594	36	0.050	8.90	14.00	09 Anterior Abdominal Hernia Repair	500	318
49561	D	12,726	49594	3,818	0.300	15.38	14.00	09 Anterior Abdominal Hernia Repair	53,449	58,718
49655	D	4,804	49594	1,441	0.300	16.84	14.00	09 Anterior Abdominal Hernia Repair	20,177	24,270

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
49572	D	451	49594	5	0.010	7.87	14.00	09 Anterior Abdominal Hernia Repair	63	35
49587	D	7,947	49594	1,113	0.140	7.08	14.00	09 Anterior Abdominal Hernia Repair	15,576	7,877
49653	D	5,848	49594	819	0.140	14.94	14.00	09 Anterior Abdominal Hernia Repair	11,462	12,232
49561	D	12,726	49596	509	0.040	15.38	20.00	09 Anterior Abdominal Hernia Repair	10,181	7,829
49655	D	4,804	49596	192	0.040	16.84	20.00	09 Anterior Abdominal Hernia Repair	3,843	3,236
49587	D	7,947	49596	79	0.010	7.08	20.00	09 Anterior Abdominal Hernia Repair	1,589	563
49653	D	5,848	49596	58	0.010	14.94	20.00	09 Anterior Abdominal Hernia Repair	1,170	874
49565	D	5,211	49613	1,303	0.250	12.37	7.75	09 Anterior Abdominal Hernia Repair	10,096	16,115
49656	D	1,697	49613	339	0.200	15.08	7.75	09 Anterior Abdominal Hernia Repair	2,630	5,118
49565	D	5,211	49615	3,387	0.650	12.37	12.00	09 Anterior Abdominal Hernia Repair	40,646	41,899
49656	D	1,697	49615	1,188	0.700	15.08	12.00	09 Anterior Abdominal Hernia Repair	14,255	17,914
49565	D	5,211	49617	469	0.090	12.37	16.97	09 Anterior Abdominal Hernia Repair	7,959	5,801
49656	D	1,697	49617	153	0.090	15.08	16.97	09 Anterior Abdominal Hernia Repair	2,592	2,303
49566	D	3,748	49614	750	0.200	15.53	10.79	09 Anterior Abdominal Hernia Repair	8,088	11,641
49657	D	1,503	49614	301	0.200	22.11	10.79	09 Anterior Abdominal Hernia Repair	3,243	6,646
49566	D	3,748	49616	2,624	0.700	15.53	16.50	09 Anterior Abdominal Hernia Repair	43,289	40,745
49657	D	1,503	49616	1,052	0.700	22.11	16.50	09 Anterior Abdominal Hernia Repair	17,360	23,262
49566	D	3,748	49618	337	0.090	15.53	24.00	09 Anterior Abdominal Hernia Repair	8,096	5,239
49657	D	1,503	49618	135	0.090	22.11	24.00	09 Anterior Abdominal Hernia Repair	3,246	2,991
49560	D	22,089	49621	221	0.010	11.92	14.24	09 Anterior Abdominal Hernia Repair	3,145	2,633
49654	D	7,253	49621	73	0.010	13.76	14.24	09 Anterior Abdominal Hernia Repair	1,033	998
49565	D	5,211	49621	52	0.010	12.37	14.24	09 Anterior Abdominal Hernia Repair	742	645
49656	D	1,697	49621	17	0.010	15.08	14.24	09 Anterior Abdominal Hernia Repair	242	256
49561	D	12,726	49622	127	0.010	15.38	18.00	09 Anterior Abdominal Hernia Repair	2,291	1,957
49655	D	4,804	49622	48	0.010	16.84	18.00	09 Anterior Abdominal Hernia Repair	865	809
49566	D	3,748	49622	37	0.010	15.53	18.00	09 Anterior Abdominal Hernia Repair	675	582
49657	D	1,503	49622	15	0.010	22.11	18.00	09 Anterior Abdominal Hernia Repair	271	332
49568	D	27,767	15778	278	0.010	4.88	8.00	09 Anterior Abdominal Hernia Repair	2,221	1,355
49568	D	27,767	Util Savings (bundled into X01-X12)	27,489	0.990	4.88	0.00	09 Anterior Abdominal Hernia Repair	0	134,148
49659		980	49621	147	0.150	0.00	14.24	09 Anterior Abdominal Hernia Repair	2,093	0
49999		1,327	49621	199	0.150	0.00	14.24	09 Anterior Abdominal Hernia Repair	2,834	0
49659		980	49622	343	0.350	0.00	18.00	09 Anterior Abdominal Hernia Repair	6,174	0
49999		1,327	49622	464	0.350	0.00	18.00	09 Anterior Abdominal Hernia Repair	8,360	0
49659		980	49623	98	0.100	0.00	5.00	09 Anterior Abdominal Hernia Repair	490	0
49999		1,327	49623	100	0.075	0.00	5.00	09 Anterior Abdominal Hernia Repair	500	0
49999		1,327	15778	13	0.010	0.00	8.00	09 Anterior Abdominal Hernia Repair	106	0
49999		1,327	49999	550	0.415	0.00	0.00	09 Anterior Abdominal Hernia Repair	0	0
49580	D	-	Savings	-	1.000	4.47	0.00	09 Anterior Abdominal Hernia Repair	0	0
49582	D	-	Savings	-	1.000	7.13	0.00	09 Anterior Abdominal Hernia Repair	0	0
99212 visits bundled into surgical global for deleted codes 49560-49657	D	-	99212	114,936	1.000	0.00	0.70	09 Anterior Abdominal Hernia Repair	80,455	0
99213 visits bundled into surgical global for deleted codes 49560-49657	D	-	99213	102,781	1.000	0.00	1.30	09 Anterior Abdominal Hernia Repair	133,615	0
99231 visits bundled into surgical global for deleted codes 49561-49657	D	-	99231	25,336	1.000	0.00	0.76	09 Anterior Abdominal Hernia Repair	19,255	0

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
99232 visits bundled into surgical global for deleted codes 49561-49657	D	-	99232	43,764	1.000	0.00	1.39	09 Anterior Abdominal Hernia Repair	60,832	0
92065		32,858	92065	14,786	0.450	0.37	0.71	10 Orthoptic Training	10,498	5,471
92065		32,858	92066	18,072	0.550	0.37	0.00	10 Orthoptic Training	0	6,687
New service not currently reported		-	96202	-	1.000	0.00	0.43	11 Caregiver Behavior Management Training	0	0
New service not currently reported		-	96203	-	1.000	0.00	0.12	11 Caregiver Behavior Management Training	0	0
99281		67,730	99281	67,730	1.000	0.48	0.25	12 Emergency Department Services	16,933	32,510
99282		352,496	99282	352,496	1.000	0.93	0.93	12 Emergency Department Services	327,821	327,821
99283		2,744,710	99283	2,744,710	1.000	1.60	1.60	12 Emergency Department Services	4,391,536	4,391,536
99284		5,415,650	99284	5,415,650	1.000	2.74	2.60	12 Emergency Department Services	14,080,690	14,838,881
99285		11,514,274	99285	11,514,274	1.000	4.00	4.00	12 Emergency Department Services	46,057,096	46,057,096
99304		336,776	99304	336,776	1.000	1.64	1.50	13 Nursing Facility Services	505,164	552,313
99305		1,054,727	99305	1,054,727	1.000	2.35	2.50	13 Nursing Facility Services	2,636,818	2,478,608
99306		1,389,990	99306	1,389,990	1.000	3.06	3.50	13 Nursing Facility Services	4,864,965	4,253,369
99307		2,372,760	99307	2,372,760	1.000	0.76	0.70	13 Nursing Facility Services	1,660,932	1,803,298
99308		11,302,104	99308	11,302,104	1.000	1.16	1.30	13 Nursing Facility Services	14,692,735	13,110,441
99309		10,009,767	99309	10,009,767	1.000	1.55	1.92	13 Nursing Facility Services	19,218,753	15,515,139
99310		1,671,664	99310	1,671,664	1.000	2.35	2.80	13 Nursing Facility Services	4,680,659	3,928,410
99318	D	100,126	99308	10,013	0.100	1.71	1.30	13 Nursing Facility Services	13,017	17,122
99318	D	100,126	99309	85,107	0.850	1.71	1.92	13 Nursing Facility Services	163,405	145,533
99318	D	100,126	99310	5,006	0.050	1.71	2.80	13 Nursing Facility Services	14,017	8,560
99415		4,248	99415	4,248	1.000	0.00	0.00	15 Prolonged Services - Clinical Staff Services (PE Only)	0	0
99416		1,382	99416	1,382	1.000	0.00	0.00	15 Prolonged Services - Clinical Staff Services (PE Only)	0	0
99483		45,645	99483	45,645	1.000	3.80	3.50	16 Cognitive Assessment and Care Plan Services	159,758	173,451
22869		6,795	22869	6,795	1.000	7.03	7.03	17 Insertion of Spinal Stability Distractive Device	47,769	47,769
22870		2,884	22870	2,884	1.000	2.34	2.34	17 Insertion of Spinal Stability Distractive Device	6,749	6,749
27446		15,803	27446	15,803	1.000	17.48	17.13	18 Knee Arthroplasty	270,705	276,236
27447		312,130	27447	312,130	1.000	19.60	19.60	18 Knee Arthroplasty	6,117,748	6,117,748
90460		301	90460	301	1.000	0.17	0.24	19 Immunization Administration	72	51
90461		58	90461	58	1.000	0.15	0.18	19 Immunization Administration	10	9
90471		282,357	90471	282,357	1.000	0.17	0.17	19 Immunization Administration	48,001	48,001
90472		22,524	90472	22,524	1.000	0.15	0.15	19 Immunization Administration	3,379	3,379
90473		3	90473	3	1.000	0.17	0.17	19 Immunization Administration	1	1
90474		1	90474	1	1.000	0.15	0.15	19 Immunization Administration	0	0
G0008		15,066,497	G0008	15,066,497	1.000	0.17	0.17	19 Immunization Administration	2,561,304	2,561,304
G0009		3,142,650	G0009	3,142,650	1.000	0.17	0.17	19 Immunization Administration	534,251	534,251
G0010		71,927	G0010	71,927	1.000	0.17	0.17	19 Immunization Administration	12,228	12,228
92284		32,615	92284	32,615	1.000	0.24	0.14	20 Dark Adaptation Eye Exam	4,566	7,828
92287		7,182	92287	7,182	1.000	0.81	0.40	21 Anterior Segment Imaging	2,873	5,817
0290T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0423T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0451T	D	1	Savings	1	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0452T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0453T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0454T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0455T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0456T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0457T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
0458T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0459T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0460T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0461T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0462T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
0463T	D	-	Savings	-	1.000	0.00	0.00	Category III Sundown for CPT 2022	0	0
33470	D	-	Savings	-	1.000	21.54	0.00	Code Set Maintenance for CPT 2022	0	0
33722	D	-	Savings	-	1.000	29.21	0.00	Code Set Maintenance for CPT 2022	0	0
59135	D	-	Savings	-	1.000	14.92	0.00	Code Set Maintenance for CPT 2022	0	0
63196	D	-	Savings	-	1.000	25.27	0.00	Code Set Maintenance for CPT 2022	0	0
63198	D	-	Savings	-	1.000	29.90	0.00	Code Set Maintenance for CPT 2022	0	0
63199	D	-	Savings	-	1.000	31.47	0.00	Code Set Maintenance for CPT 2022	0	0
92559	D	-	Savings		1.000	0.00	0.00	Vestibular and Audiologic Function Test	0	0
92560	D	-	Savings		1.000	0.00	0.00	Vestibular and Audiologic Function Test	0	0
92561	D	345	Savings	345	1.000	0.00	0.00	Vestibular and Audiologic Function Test	0	0
92564	D	484	Savings	484	1.000	0.00	0.00	Vestibular and Audiologic Function Test	0	0
									129,503,943	124,551,303

Total Source RVUs	124,551,303
Total New/Revised RVUs	129,503,943
RVU Difference	(4,952,640)
CF	34.8931
CF Redistribution	**$ (172,812,961)**

CPT Code	2019 Medicare Util	Using 2021 wRVUs (exc. Discharge)	Service Pac	99204	99211	99212
49560	22,089	44,178		0	0	1
49561	12,726	70,502		0	0	1
49565	5,211	21,626		0	0	1
49566	3,748	20,764		0	0	1
49568	27,767	-		0	0	0
49570	616	1,232		0	0	1
49572	451	2,499		0	0	1
49580	-	-		0	0	1
49582	-	-		0	0	1
49585	18,847	37,694		0	0	1
49587	7,947	15,894	4	0	0	1
49590	714	1,428		0	0	1
49652	9,327	18,654	4	0	0	1
49653	5,848	15,790	4	0	0	2
49654	7,253	14,506	4	0	0	1
49655	4,804	12,971	4	0	0	2
49656	1,697	7,043		0	0	1
49657	1,503	9,379		0	0	2

294,158

99212 unbundled util	99213	99213 unbundled util	99214	99215	99231	1 unbundle	99232
22,089	1	22,089	0	0	0	-	0
12,726	1	12,726	0	0	1	12,726	2
5,211	1	5,211	0	0	1	5,211	1
3,748	1	3,748	0	0	1	3,748	2
-	0	-	0	0	0	-	0
616	1	616	0	0	0	-	0
451	1	451	0	0	1	451	2
-	1	-	0	0	0	-	0
-	1	-	0	0	1	-	0
18,847	1	18,847	0	0	0	-	0
7,947	1	7,947	0	0	0	-	0
714	1	714	0	0	0	-	0
9,327	1	9,327	0	0	0	-	0
11,696	1	5,848	0	0	0	-	0
7,253	1	7,253	0	0	0	-	0
9,608	1	4,804	0	0	0	-	0
1,697	1	1,697	0	0	1	1,697	1
3,006	1	1,503	0	0	1	1,503	2
114,936		102,781				25,336	

2 unbundle	99233	99238	99239	99291	99292	tical Care Ti	l & Discha	rice Visits T	tegate Pre T
-	0	0.5					19	39	45
25,452	0	1					138	39	45
5,211	0	1					98	39	45
7,496	0	1					138	39	45
-	0								
-	0	0.5					19	39	45
902	0	1					138	39	45
-	0	0.5					19	39	45
-	0	1					58	39	45
-	0	0.5					19	39	45
-	0	0.5					19	39	63
-	0	0.5					19	39	45
-	0	0.5					19	39	70
-	0	0.5					19	55	70
-	0	0.5					19	39	70
-	0	0.5					19	55	70
1,697	0	1					98	39	75
3,006	0	1					138	55	90

43,764

egate Post	ate Pre-Pos	Total Time	C Time Sou	IWPUT
88	133	223	RUC	0.0906
207	252	352	RUC	0.0743
167	212	312	RUC	0.0581
207	252	372	RUC	0.0632
		52	RUC	0.0938
88	133	193	RUC	0.038
207	252	312	RUC	-0.0013
88	133	170.5	RUC	0.0187
127	172	219.5	RUC	0.0413
88	133	178	RUC	0.0627
98	161	221	RUC-CMS Revised	0.0495
88	133	193	RUC	0.0855
98	168	258	RUC-CMS Revised	0.0842
124	194	314	RUC-CMS Revised	0.0825
108	178	298	RUC-CMS Revised	0.0766
124	194	344	RUC-CMS Revised	0.0786
167	242	362	RUC	0.0672
223	313	493	RUC	0.0716

New Technology/New Services List

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage, single dose	Jan 2021	Janssen-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; first dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; second dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	October 2015	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Oct 2016	Intraoperative Radiation Therapy Applicator Procedures	07	CPT 2018	January 2022		☐
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐
20561	Needle insertion(s) without injection(s); 3 or more muscles	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20700	Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20701	Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20703	Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20705	Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Apr 2014	Cryoablation Treatment of the Bone Tumors	04	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	☑
20986	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
20987	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Apr 2014	Total Disc Arthroplasty Additional Cervical Level Add-On Code	07	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☑
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☑
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Apr 2014	Sacroiliac Joint Fusion	08	CPT 2015	October 2018	Surveyed in April 2018 for a CMS Request in the Final Rule for 2018	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Sep 2014	Sacroiliac Joint Fusion	06	CPT 2016	October 2019	Remove form list, was only identified with 27279 and that code has been resurveyed April 2018.	☑
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
29582	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29583	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	January 2022	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	☑
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	October 2016	Review practice expense January 2014. Review data again in 3 years (Sept 2016).	☑
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Jan 2017	Cryoablation of Pulmonary Tumors	08	CPT 2018	January 2022		☐
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	January 2023		☐
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	January 2023		☐
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
33286	Removal, subcutaneous cardiac rhythm monitor	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	January 2023		☐
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Jan 2016	Closure Left Atrial Appendage with Endocardial Implant	10	CPT 2017	January 2023	Review in two years (January 2023); new FDA indication recently released, suggesting this service is still changing.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023		☐
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Jan 2015	Transcatheter Pulmonary Valve Implantation	06	CPT 2016	January 2023	Review in 3 years (January 2023); pediatric procedure with some CMS utilization.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	Oct 2018	Aortic Graft Procedures	06	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	January 2022		☐
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	January 2022		☐
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	January 2022		☐
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	January 2025		☐
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	January 2025		☐
33XX3		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33XX4		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33XX5		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33XXX		Jan 2021	Percutaneous Cerebral Embolic Protection	07	CPT 2022	January 2026		☐
34806	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
35XX0		Jan 2021	Harvest of Upper Extremity Artery, Endoscopic and Open	09	CPT 2022	January 2026		☐
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	January 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	January 2022		☐
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	January 2022	Review in January 2022 with the other codes in this family identified via the 2022 new technology/new services screen (36475-36479).	☐
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	January 2022	Review in January 2022 with the other codes in this family identified via the 2022 new technology/new services screen (36475-36479).	☐
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	January 2022		☐
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	January 2022		☐
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Apr 2014	Transcatheter Placement of Carotid Stents	12	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	January 2022		☐
38221	Diagnostic bone marrow; biopsy(ies)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	January 2022		☐
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	January 2022		☐
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Jan 2014	Endoscopic Hypopharyngeal Diverticulotomy	7	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Apr 2015	Esophagogatric Fundoplasty Trans-Oral Approach	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	☑
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
434XX		Oct 2020	Per-Oral Endoscopic Myotomy (POEM)	07	CPT 2022	January 2026		☐
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013	Remove from list, carrier priced.	☑
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43X21		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐
43X22		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In Octobre 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Apr 2014	High Resolution Anoscopy	14	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Apr 2014	High Resolution Anoscopy	14	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	Oct 2018	Transanal Hemorrhoidal Dearterialization	07	CPT 2020	January 2024		☐
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Apr 2014	Cryoablation of Liver Tumor	15	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Jan 2018	Transurethral Destruction of Prostate Tissue	13	CPT 2019	January 2023		☐
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.	☑
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Jan 2017	Peri-Prostatic Implantation of Biodegradable Material	13	CPT 2018	January 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Oct 2019	Transrectal High Intesity Focused US Prostate Ablation	06	CPT 2021	January 2025		☐
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)	Jan 2020	Computer-Aided Mapping of Cervix Uteri	14	CPT 2021	January 2025		☐
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Jan 2016	Laparoscopic Radiofrequency Ablation of Uterine Fibroids	18	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
617X1		Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
617X2		Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	January 2024		☐
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	January 2024		☐
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Jan 2016	Endoscopic Decompression of Spinal Cord Nerve	19	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	January 2024		☐
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	October 2019	Surveyed for April 2015, RUC recommended to review utilization again in 2 years (Oct 2019). In Oct 2019, recommended to remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
646X0		Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
646X1		Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	☑
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated.	☑
65778	Placement of amniotic membrane on the ocular surface; without sutures	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014	Survey for April 2015.	☑
65785	Implantation of intrastromal corneal ring segments	Jan 2015	Intrastomal Corneal Ring Implantation	11	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Apr 2013	Insertion of Anterior Segment	14	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
66982		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
66984		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
66987		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
66988		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
669X1		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
669X2		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2026		☐
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
68XXX		Jan 2021	Lacrimal Canaliculus Drug Eluting Implant Insertion	17	CPT 2022	January 2026		☐
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Oct 2019	Screening CT of Thorax	07	CPT 2021	January 2025		☐
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	☑
75558	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75560	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	☑
75562	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75564	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
76391	Magnetic resonance (eg, vibration) elastography	Jan 2018	Magnetic Resonance Elastography	16	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	January 2022	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	January 2022	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	January 2023		☐
76981	Ultrasound, elastography; parenchyma (eg, organ)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76982	Ultrasound, elastography; first target lesion	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77061	Diagnostic digital breast tomosynthesis; unilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	January 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77062	Diagnostic digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	January 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	January 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)	Jan 2013	Respiratory Motion Management Simulation	14	CPT 2014	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	October 2015	Practice expense review (Feb 2011).	☑
77520	Proton treatment delivery; simple, without compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77522	Proton treatment delivery; simple, with compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77523	Proton treatment delivery; intermediate	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77525	Proton treatment delivery; complex	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77X01		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77X02		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77X03		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77X04		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid scintigraphy as an	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid scintigraphy as an	☑

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							effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	October 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81244	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), Y438N variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion CLRN1 (clarin 1) (eg, Usher syndrome, type 3), N48K variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant FGFR1 (fibroblast growth factor receptor 1) (eg, Pfeiffer syndrome type 1, craniosynostosis), P252R variant FGFR3 (fibroblast growth factor receptor 3) (eg, Muenke syndrome), P250R variant FKTN (fukutin) (eg, Fukuyama congenital muscular dystrophy), retrotransposon insertion variant GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), M712T variant IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), A282V variant LCT (lactase-phlorizin hydrolase) (eg, lactose intolerance), 13910 C>T variant NEB (nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), R245X variant	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), S2G variant SRY (sex determining region Y) (eg, 46,XX testicular disorder of sex development, gonadal dysgenesis), gene analysis TOR1A (torsin family 1, member A [torsin A]) (eg, early-onset primary dystonia [DYT1]), 907_909delGAG (904_906delGAG) variant							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9G>A [c.3992-9G>A], F1388del) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B), common variants (eg, R3500Q, R3500W) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), common variants (eg, I278T, G307S) CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) DEK/NUP214 (t(6;9)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed E2A/PBX1 (t(1;19)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EML4/ALK (inv(2)) (eg, non-small cell lung cancer), translocation or inversion analysis ETV6/RUNX1 (t(12;21)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EWSR1/ATF1 (t(12;22)) (eg, clear cell sarcoma), translocation analysis, qualitative, and quantitative, if performed EWSR1/ERG (t(21;22)) (eg, Ewing sarcoma/peripheral neuroectodermal	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/FLI1 (t(11;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/WT1 (t(11;22)) (eg, desmoplastic small round cell tumor), translocation analysis, qualitative, and quantitative, if performed F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), common variants (eg, 1138G>A, 1138G>C, 1620C>A, 1620C>G) FIP1L1/PDGFRA (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed FLG (filaggrin) (eg, ichthyosis vulgaris), common variants (eg, R501X, 2282del4, R2447X, S3247X, 3702delG) FOXO1/PAX3 (t(2;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FOXO1/PAX7 (t(1;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FUS/DDIT3 (t(12;16)) (eg, myxoid liposarcoma), translocation analysis, qualitative, and quantitative, if performed GALC (galactosylceramidase) (eg, Krabbe disease), common variants (eg, c.857G>A, 30-kb deletion) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D) H19 (imprinted maternally expressed transcript [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; single breakpoint (eg, major breakpoint region [MBR] or minor cluster region [mcr]), qualitative or quantitative (When both MBR and mcr breakpoints are performed, use 81278) KCNQ1OT1 (KCNQ1 overlapping transcript 1 [non-							

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	protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis LINC00518 (long intergenic non-protein coding RNA 518) (eg, melanoma), expression analysis LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), common variants (eg, R1441G, G2019S, I2020T) MED12 (mediator complex subunit 12) (eg, FG syndrome type 1, Lujan syndrome), common variants (eg, R961W, N1007S) MEG3/DLK1 (maternally expressed 3 [non-protein coding]/delta-like 1 homolog [Drosophila]) (eg, intrauterine growth retardation), methylation analysis MLL/AFF1 (t(4;11)) (eg, acute lymphoblastic leukemia), translocation analysis, qualitative, and quantitative, if performed MLL/MLLT3 (t(9;11)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed MT-ATP6 (mitochondrially encoded ATP synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome), common variants (eg, m.8993T>G, m.8993T>C) MT-ND4, MT-ND6 (mitochondrially encoded NADH dehydrogenase 4, mitochondrially encoded NADH dehydrogenase 6) (eg, Leber hereditary optic neuropathy [LHON]), common variants (eg, m.11778G>A, m.3460G>A, m.14484T>C) MT-ND5 (mitochondrially encoded tRNA leucine 1 [UUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A>G, m.3271T>C, m.3252A>G, m.13513G>A) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), common variants (eg, m.1555A>G, m.1494C>T) MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A>G, m.8356T>C) MT-TL1 (mitochondrially encoded tRNA leucine 1 [UUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A>G, m.14709 T>C) MT-TL1 MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN],							

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	mitochondrially encoded 12S RNA) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A>G, m.1555A>G) MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), common variants (eg, Y165C, G382D) NOD2 (nucleotide-binding oligomerization domain containing 2) (eg, Crohn's disease, Blau syndrome), common variants (eg, SNP 8, SNP 12, SNP 13) NPM1/ALK (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis PAX8/PPARG (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis PRAME (preferentially expressed antigen in melanoma) (eg, melanoma), expression analysis PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, N29I, A16V, R122H) PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), common variants (eg, R50X, G205S) RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SS18/SSX1 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed SS18/SSX2 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)							

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81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) TRD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), duplication/deletion analysis CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY]), targeted sequence analysis of exon 11 (eg, c.1785delC, c.1686delT) CTNNB1 (catenin [cadherin-associated protein], beta 1, 88kDa) (eg, desmoid tumors), targeted sequence analysis (eg, exon 3) DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) DNMT3A (DNA [cytosine-5-]-methyltransferase 3 alpha) (eg, acute myeloid leukemia), targeted sequence analysis (eg, exon 23) EPCAM (epithelial cell adhesion molecule) (eg, Lynch syndrome), duplication/deletion analysis F8 (coagulation factor VIII) (eg, hemophilia A), inversion analysis, intron 1 and intron 22A F12 (coagulation factor XII [Hageman factor]) (eg, angioedema, hereditary, type III; factor XII deficiency), targeted sequence analysis of exon 9 FGFR3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (For targeted sequence analysis of multiple FGFR3 exons, use 81404) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence GNAQ (guanine nucleotide-binding protein G[q] subunit alpha) (eg, uveal melanoma), common variants (eg, R183, Q209) Human erythrocyte antigen gene analyses (eg, SLC14A1 [Kidd blood group], BCAM [Lutheran blood group], ICAM4 [Landsteiner-Wiener blood group], SLC4A1 [Diego blood group], AQP1 [Colton blood group], ERMAP	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	[Scianna blood group], RHCE [Rh blood group, CcEe antigens], KEL [Kell blood group], DARC [Duffy blood group], GYPA, GYPB, GYPE [MNS blood group], ART4 [Dombrock blood group]) (eg, sickle-cell disease, thalassemia, hemolytic transfusion reactions, hemolytic disease of the fetus or newborn), common variants HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), exon 2 sequence KCNC3 (potassium voltage-gated channel, Shaw-related subfamily, member 3) (eg, spinocerebellar ataxia), targeted sequence analysis (eg, exon 2) KCNJ2 (potassium inwardly-rectifying channel, subfamily J, member 2) (eg, Andersen-Tawil syndrome), full gene sequence KCNJ11 (potassium inwardly-rectifying channel, subfamily J, member 11) (eg, familial hyperinsulinism), full gene sequence Killer cell immunoglobulin-like receptor (KIR) gene family (eg, hematopoietic stem cell transplantation), genotyping of KIR family genes Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, or identified during a genomic sequencing procedure, DNA sequence analysis, each variant exon (For a known familial variant that is considered a common variant, use specific common variant Tier 1 or Tier 2 code) MC4R (melanocortin 4 receptor) (eg, obesity), full gene sequence MICA (MHC class I polypeptide-related sequence A) (eg, solid organ transplantation), common variants (eg, *001, *002) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), duplication/deletion analysis NHLRC1 (NHL repeat containing 1) (eg, progressive myoclonus epilepsy), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), duplication/deletion analysis PLN (phospholamban) (eg, dilated cardiomyopathy, hypertrophic cardiomyopathy),							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	full gene sequence RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene) RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene), performed on cell-free fetal DNA in maternal blood (For human erythrocyte gene analysis of RHD, use a separate unit of 81403) SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), duplication/deletion analysis TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), duplication/deletion analysis UBA1 (ubiquitin-like modifier activating enzyme 1) (eg, spinal muscular atrophy, X-linked), targeted sequence analysis (eg, exon 15) VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), full gene sequence AVPR2 (arginine vasopressin receptor 2) (eg, nephrogenic diabetes insipidus), full gene sequence BBS10 (Bardet-Biedl syndrome 10) (eg, Bardet-Biedl syndrome), full gene sequence BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence C10orf2 (chromosome 10 open reading frame 2) (eg, mitochondrial DNA depletion syndrome), full gene sequence CAV3 (caveolin 3) (eg, CAV3-related distal myopathy, limb-girdle muscular dystrophy type 1C), full gene sequence CD40LG (CD40 ligand) (eg, X-linked hyper IgM syndrome), full gene sequence CDKN2A (cyclin-dependent kinase inhibitor 2A) (eg, CDKN2A-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence CLRN1 (clarin 1) (eg, Usher syndrome, type 3), full gene sequence COX6B1 (cytochrome c oxidase subunit VIb polypeptide 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPT2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase II deficiency), full gene sequence CRX (cone-rod homeobox) (eg, cone-rod dystrophy 2, Leber congenital amaurosis), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence EGR2 (early growth response 2) (eg, Charcot-Marie-Tooth), full gene sequence EMD (emerin) (eg,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	Emery-Dreifuss muscular dystrophy), duplication/deletion analysis EPM2A (epilepsy, progressive myoclonus type 2A, Lafora disease [laforin]) (eg, progressive myoclonus epilepsy), full gene sequence FGF23 (fibroblast growth factor 23) (eg, hypophosphatemic rickets), full gene sequence FGFR2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, Apert syndrome, Crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) FHL1 (four and a half LIM domains 1) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence FKRP (fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence FOXG1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) GH1 (growth hormone 1) (eg, growth hormone deficiency), full gene sequence GP1BB (glycoprotein Ib [platelet], beta polypeptide) (eg, Bernard-Soulier syndrome type B), full gene sequence (For common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), full gene sequence HSD3B2 (hydroxy-delta-5-steroid dehydrogenase, 3 beta- and steroid delta-isomerase 2) (eg, 3-beta-hydroxysteroid dehydrogenase type II deficiency), full gene sequence HSD11B2 (hydroxysteroid [11-beta] dehydrogenase 2) (eg, mineralocorticoid excess							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	syndrome), full gene sequence HSPB1 (heat shock 27kDa protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence INS (insulin) (eg, diabetes mellitus), full gene sequence KCNJ1 (potassium inwardly-rectifying channel, subfamily J, member 1) (eg, Bartter syndrome), full gene sequence KCNJ10 (potassium inwardly-rectifying channel, subfamily J, member 10) (eg, SeSAME syndrome, EAST syndrome, sensorineural hearing loss), full gene sequence LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), duplication/deletion analysis MMACHC (methylmalonic aciduria [cobalamin deficiency] cblC type, with homocystinuria) (eg, methylmalonic acidemia and homocystinuria), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), duplication/deletion analysis NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), full gene sequence NDUFA1 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, 1, 7.5kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFAF2 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, assembly factor 2) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS4 (NADH dehydrogenase [ubiquinone] Fe-S protein 4, 18kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NIPA1 (non-imprinted in Prader-Willi/Angelman syndrome 1) (eg, spastic paraplegia), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), duplication/deletion analysis NPC2 (Niemann-Pick disease, type C2 [epididymal secretory protein E1]) (eg, Niemann-Pick disease type C2), full gene sequence NR0B1 (nuclear								

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	receptor subfamily 0, group B, member 1) (eg, congenital adrenal hypoplasia), full gene sequence PDX1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), duplication/deletion analysis PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), duplication/deletion analysis PRNP (prion protein) (eg, genetic prion disease), full gene sequence PROP1 (PROP paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence PRPH2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma), common variants (eg, M918T, 2647_2648delinsTT, A883F) RHO (rhodopsin) (eg, retinitis pigmentosa), full gene sequence RP1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence SCN1B (sodium channel, voltage-gated, type I, beta) (eg, Brugada syndrome), full gene sequence SCO2 (SCO cytochrome oxidase deficient homolog 2 [SCO1L]) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular							

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	dystrophy), duplication/deletion analysis SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), duplication/deletion analysis SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), duplication/deletion analysis SLC25A4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence SOD1 (superoxide dismutase 1, soluble) (eg, amyotrophic lateral sclerosis), full gene sequence SPINK1 (serine peptidase inhibitor, Kazal type 1) (eg, hereditary pancreatitis), full gene sequence STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), duplication/deletion analysis TACO1 (translational activator of mitochondrial encoded cytochrome c oxidase I) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence THAP1 (THAP domain containing, apoptosis associated protein 1) (eg, torsion dystonia), full gene sequence TOR1A (torsin family 1, member A [torsin A]) (eg, torsion dystonia), full gene sequence TTPA (tocopherol [alpha] transfer protein) (eg, ataxia), full gene sequence TTR (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), full gene sequence TYR (tyrosinase [oculocutaneous albinism IA]) (eg, oculocutaneous albinism IA), full gene sequence UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, hereditary unconjugated hyperbilirubinemia [Crigler-Najjar syndrome]) full gene sequence USH1G (Usher syndrome 1G [autosomal recessive]) (eg, Usher syndrome, type 1), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial							

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	cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37) ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), duplication/deletion analysis ZNF41 (zinc finger protein 41) (eg, X-linked mental retardation 89), full gene sequence							

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81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence ANKRD1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence ARSA (arylsulfatase A) (eg, arylsulfatase A deficiency), full gene sequence BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), full gene sequence BCS1L (BCS1-like [S. cerevisiae]) (eg, Leigh syndrome, mitochondrial complex III deficiency, GRACILE syndrome), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), duplication/deletion analysis CASQ2 (calsequestrin 2 [cardiac muscle]) (eg, catecholaminergic polymorphic ventricular tachycardia), full gene sequence CASR (calcium-sensing receptor) (eg, hypocalcemia), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), duplication/deletion analysis CHRNA4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence CHRNB2 (cholinergic receptor, nicotinic, beta 2 [neuronal]) (eg, nocturnal frontal lobe epilepsy), full gene sequence COX10 (COX10 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence COX15 (COX15 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPOX (coproporphyrinogen oxidase) (eg, hereditary coproporphyria), full gene sequence CTRC (chymotrypsin C) (eg, hereditary pancreatitis), full gene sequence CYP11B1 (cytochrome P450, family 11, subfamily B, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP17A1 (cytochrome P450, family 17, subfamily A, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence Cytogenomic constitutional targeted microarray analysis of chromosome 22q13 by interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (When performing genome-wide cytogenomic constitutional microarray analysis, see 81228, 81229) (Do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (Do not report 88271 when performing cytogenomic microarray analysis) DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis DCX (doublecortin) (eg, X-linked lissencephaly), full gene sequence DES (desmin) (eg, myofibrillar myopathy), full gene sequence DFNB59 (deafness, autosomal recessive 59) (eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence DGUOK (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial DNA depletion syndrome), full gene sequence DHCR7 (7-dehydrocholesterol reductase) (eg, Smith-Lemli-Opitz syndrome), full gene sequence EIF2B2 (eukaryotic translation initiation factor 2B, subunit 2 beta, 39kDa) (eg,							

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	leukoencephalopathy with vanishing white matter), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), duplication/deletion analysis EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), duplication/deletion analysis FGFR1 (fibroblast growth factor receptor 1) (eg, Kallmann syndrome 2), full gene sequence FH (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), duplication/deletion analysis GABRG2 (gamma-aminobutyric acid [GABA] A receptor, gamma 2) (eg, generalized epilepsy with febrile seizures), full gene sequence GCH1 (GTP cyclohydrolase 1) (eg, autosomal dominant dopa-responsive dystonia), full gene sequence GDAP1 (ganglioside-induced differentiation-associated protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence GFAP (glial fibrillary acidic protein) (eg, Alexander disease), full gene sequence GHR (growth hormone receptor) (eg, Laron syndrome), full gene sequence GHRHR (growth hormone releasing hormone receptor) (eg, growth hormone deficiency), full gene sequence GLA (galactosidase, alpha) (eg, Fabry disease), full gene sequence HNF1A (HNF1 homeobox A) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HTRA1 (HtrA serine peptidase 1) (eg, macular degeneration), full gene sequence IDS (iduronate 2-sulfatase) (eg, mucopolysacchridosis, type II), full gene sequence IL2RG (interleukin 2 receptor, gamma) (eg, X-linked severe combined immunodeficiency), full gene sequence ISPD (isoprenoid synthase							

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	domain containing) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, Noonan syndrome), full gene sequence LAMP2 (lysosomal-associated membrane protein 2) (eg, Danon disease), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), duplication/deletion analysis MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), full gene sequence MMAA (methylmalonic aciduria [cobalamine deficiency] type A) (eg, MMAA-related methylmalonic acidemia), full gene sequence MMAB (methylmalonic aciduria [cobalamine deficiency] type B) (eg, MMAA-related methylmalonic acidemia), full gene sequence MPI (mannose phosphate isomerase) (eg, congenital disorder of glycosylation 1b), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), duplication/deletion analysis MYL2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYL3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYOT (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence NDUFS7 (NADH dehydrogenase [ubiquinone] Fe-S protein 7, 20kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS8 (NADH dehydrogenase [ubiquinone] Fe-S protein 8, 23kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFV1 (NADH dehydrogenase [ubiquinone] flavoprotein 1, 51kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), duplication/deletion analysis NLGN3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), deletion analysis, and duplication analysis, if performed NPHS2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), duplication/deletion analysis OTC (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), duplication/deletion analysis PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), duplication/deletion analysis PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis PCDH19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), duplication/deletion analysis PDHB (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence PINK1 (PTEN induced putative kinase 1) (eg, Parkinson disease), full gene sequence PKLR (pyruvate kinase, liver and RBC) (eg, pyruvate kinase deficiency), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), full gene sequence POU1F1 (POU class 1 homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence PRX (periaxin) (eg, Charcot-Marie-Tooth disease), full gene sequence PQBP1 (polyglutamine binding							

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	protein 1) (eg, Renpenning syndrome), full gene sequence PSEN1 (presenilin 1) (eg, Alzheimer disease), full gene sequence RAB7A (RAB7A, member RAS oncogene family) (eg, Charcot-Marie-Tooth disease), full gene sequence RAI1 (retinoic acid induced 1) (eg, Smith-Magenis syndrome), full gene sequence REEP1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) RPS19 (ribosomal protein S19) (eg, Diamond-Blackfan anemia), full gene sequence RRM2B (ribonucleotide reductase M2 B [TP53 inducible]) (eg, mitochondrial DNA depletion), full gene sequence SCO1 (SCO cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence SGCA (sarcoglycan, alpha [50kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCB (sarcoglycan, beta [43kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCD (sarcoglycan, delta [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), full gene sequence SHOX (short stature homeobox) (eg, Langer mesomelic dysplasia), full gene sequence SIL1 (SIL1							

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	homolog, endoplasmic reticulum chaperone [S. cerevisiae]) (eg, ataxia), full gene sequence SLC2A1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [GLUT 1] deficiency syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), full gene sequence SLC22A5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis SPAST (spastin) (eg, spastic paraplegia), duplication/deletion analysis SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), duplication/deletion analysis SPRED1 (sprouty-related, EVH1 domain containing 1) (eg, Legius syndrome), full gene sequence STAT3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-IgE syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), full gene sequence SURF1 (surfeit 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence TARDBP (TAR DNA binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence TBX5 (T-box 5) (eg, Holt-Oram syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), duplication/deletion analysis TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid							

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	hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TK2 (thymidine kinase 2, mitochondrial) (eg, mitochondrial DNA depletion syndrome), full gene sequence TNNC1 (troponin C type 1 [slow]) (eg, hypertrophic cardiomyopathy or dilated cardiomyopathy), full gene sequence TNNI3 (troponin I, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TPM1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis TYMP (thymidine phosphorylase) (eg, mitochondrial DNA depletion syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25) WT1 (Wilms tumor 1) (eg, Denys-Drash syndrome, familial Wilms tumor), full gene sequence ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons) ACADVL (acyl-CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence AFG3L2 (AFG3 ATPase family gene 3-like 2 [S. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldehyde dehydrogenase 7 family, member A1) (eg, pyridoxine-dependent epilepsy), full gene sequence ANO5 (anoctamin 5) (eg, limb-girdle muscular dystrophy), full gene sequence ANOS1 (anosmin-1) (eg, Kallmann syndrome 1), full gene sequence APP (amyloid beta [A4] precursor protein) (eg, Alzheimer disease), full gene sequence ASS1 (argininosuccinate synthase 1) (eg, citrullinemia type I), full gene sequence ATL1 (atlastin GTPase 1) (eg, spastic paraplegia), full gene sequence ATP1A2 (ATPase, Na+/K+ transporting, alpha 2 polypeptide) (eg, familial hemiplegic migraine), full gene sequence ATP7B (ATPase, Cu++ transporting, beta polypeptide) (eg, Wilson disease), full gene sequence BBS1 (Bardet-Biedl syndrome 1) (eg, Bardet-Biedl syndrome), full gene sequence BBS2 (Bardet-Biedl syndrome 2) (eg, Bardet-Biedl syndrome), full gene sequence BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease, type 1B), full gene sequence BEST1 (bestrophin 1) (eg, vitelliform macular dystrophy), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), full gene sequence BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, Noonan syndrome), full gene sequence BSCL2 (Berardinelli-Seip congenital lipodystrophy 2 [seipin]) (eg, Berardinelli-Seip congenital	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	lipodystrophy), full gene sequence BTK (Bruton agammaglobulinemia tyrosine kinase) (eg, X-linked agammaglobulinemia), full gene sequence CACNB2 (calcium channel, voltage-dependent, beta 2 subunit) (eg, Brugada syndrome), full gene sequence CAPN3 (calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), full gene sequence CDH1 (cadherin 1, type 1, E-cadherin [epithelial]) (eg, hereditary diffuse gastric cancer), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), full gene sequence CLCN1 (chloride channel 1, skeletal muscle) (eg, myotonia congenita), full gene sequence CLCNKB (chloride channel, voltage-sensitive Kb) (eg, Bartter syndrome 3 and 4b), full gene sequence CNTNAP2 (contactin-associated protein-like 2) (eg, Pitt-Hopkins-like syndrome 1), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), duplication/deletion analysis CPT1A (carnitine palmitoyltransferase 1A [liver]) (eg, carnitine palmitoyltransferase 1A [CPT1A] deficiency), full gene sequence CRB1 (crumbs homolog 1 [Drosophila]) (eg, Leber congenital amaurosis), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), duplication/deletion analysis DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), full gene sequence DLAT (dihydrolipoamide S-acetyltransferase) (eg, pyruvate dehydrogenase E2 deficiency), full gene sequence DLD (dihydrolipoamide dehydrogenase) (eg, maple syrup urine disease, type III), full gene sequence DSC2 (desmocollin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence DSG2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	DSP (desmoplakin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 8), full gene sequence EFHC1 (EF-hand domain [C-terminal] containing 1) (eg, juvenile myoclonic epilepsy), full gene sequence EIF2B3 (eukaryotic translation initiation factor 2B, subunit 3 gamma, 58kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B4 (eukaryotic translation initiation factor 2B, subunit 4 delta, 67kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B5 (eukaryotic translation initiation factor 2B, subunit 5 epsilon, 82kDa) (eg, childhood ataxia with central nervous system hypomyelination/vanishing white matter), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), full gene sequence EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), duplication/deletion analysis FAH (fumarylacetoacetate hydrolase [fumarylacetoacetase]) (eg, tyrosinemia, type 1), full gene sequence FASTKD2 (FAST kinase domains 2) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence FIG4 (FIG4 homolog, SAC1 lipid phosphatase domain containing [S. cerevisiae]) (eg, Charcot-Marie-Tooth disease), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), full gene sequence FUS (fused in sarcoma) (eg, amyotrophic lateral sclerosis), full gene sequence GAA (glucosidase, alpha; acid) (eg, glycogen storage disease type II [Pompe disease]), full gene sequence GALC (galactosylceramidase) (eg, Krabbe disease), full gene sequence GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence GARS (glycyl-tRNA synthetase) (eg, Charcot-Marie-Tooth disease), full gene sequence GCDH (glutaryl-CoA dehydrogenase) (eg, glutaricacidemia type 1), full gene sequence GCK (glucokinase [hexokinase 4]) (eg, maturity-onset							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	diabetes of the young [MODY]), full gene sequence GLUD1 (glutamate dehydrogenase 1) (eg, familial hyperinsulinism), full gene sequence GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), full gene sequence GRN (granulin) (eg, frontotemporal dementia), full gene sequence HADHA (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein] alpha subunit) (eg, long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence HADHB (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein], beta subunit) (eg, trifunctional protein deficiency), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence HLCS (HLCS holocarboxylase synthetase) (eg, holocarboxylase synthetase deficiency), full gene sequence HMBS (hydroxymethylbilane synthase) (eg, acute intermittent porphyria), full gene sequence HNF4A (hepatocyte nuclear factor 4, alpha) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence IDUA (iduronidase, alpha-L-) (eg, mucopolysaccharidosis type I), full gene sequence INF2 (inverted formin, FH2 and WH2 domain containing) (eg, focal segmental glomerulosclerosis), full gene sequence IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), duplication/deletion analysis JUP (junction plakoglobin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence KCNH2 (potassium voltage-gated channel, subfamily H [eag-related], member 2) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ1 (potassium voltage-gated channel, KQT-like subfamily, member 1) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2) (eg,							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	epileptic encephalopathy), full gene sequence LDB3 (LIM domain binding 3) (eg, familial dilated cardiomyopathy, myofibrillar myopathy), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), full gene sequence LEPR (leptin receptor) (eg, obesity with hypogonadism), full gene sequence LHCGR (luteinizing hormone/choriogonadotropin receptor) (eg, precocious male puberty), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence LRP5 (low density lipoprotein receptor-related protein 5) (eg, osteopetrosis), full gene sequence MAP2K1 (mitogen-activated protein kinase 1) (eg, cardiofaciocutaneous syndrome), full gene sequence MAP2K2 (mitogen-activated protein kinase 2) (eg, cardiofaciocutaneous syndrome), full gene sequence MAPT (microtubule-associated protein tau) (eg, frontotemporal dementia), full gene sequence MCCC1 (methylcrotonoyl-CoA carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-CoA carboxylase deficiency), full gene sequence MCCC2 (methylcrotonoyl-CoA carboxylase 2 [beta]) (eg, 3-methylcrotonyl carboxylase deficiency), full gene sequence MFN2 (mitofusin 2) (eg, Charcot-Marie-Tooth disease), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), full gene sequence MUT (methylmalonyl CoA mutase) (eg, methylmalonic acidemia), full gene sequence MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), full gene sequence NDUFS1 (NADH dehydrogenase [ubiquinone] Fe-S protein 1, 75kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), full gene sequence NOTCH3 (notch 3) (eg, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy [CADASIL]), targeted							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence analysis (eg, exons 1-23) NPC1 (Niemann-Pick disease, type C1) (eg, Niemann-Pick disease), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis OPTN (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), full gene sequence PAX2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence PC (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence PCCB (propionyl CoA carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), duplication/deletion analysis PCSK9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence PDHX (pyruvate dehydrogenase complex, component X) (eg, lactic acidosis), full gene sequence PHEX (phosphate-regulating endopeptidase homolog, X-linked) (eg, hypophosphatemic rickets), full gene sequence PKD2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PKP2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence PNKD (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence POLG (polymerase [DNA							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence PPOX (protoporphyrinogen oxidase) (eg, variegate porphyria), full gene sequence PRKAG2 (protein kinase, AMP-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic cardiomyopathy with Wolff-Parkinson-White syndrome, lethal congenital glycogen storage disease of heart), full gene sequence PRKCG (protein kinase C, gamma) (eg, spinocerebellar ataxia), full gene sequence PSEN2 (presenilin 2 [Alzheimer disease 4]) (eg, Alzheimer disease), full gene sequence PTPN11 (protein tyrosine phosphatase, non-receptor type 11) (eg, Noonan syndrome, LEOPARD syndrome), full gene sequence PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), full gene sequence RET (ret proto-oncogene) (eg, Hirschsprung disease), full gene sequence RPE65 (retinal pigment epithelium-specific protein 65kDa) (eg, retinitis pigmentosa, Leber congenital amaurosis), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations SCN4A (sodium channel, voltage-gated, type IV, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence SCNN1A (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	SCNN1B (sodium channel, nonvoltage-gated 1, beta) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SCNN1G (sodium channel, nonvoltage-gated 1, gamma) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SDHA (succinate dehydrogenase complex, subunit A, flavoprotein [Fp]) (eg, Leigh syndrome, mitochondrial complex II deficiency), full gene sequence SETX (senataxin) (eg, ataxia), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), full gene sequence SH3TC2 (SH3 domain and tetratricopeptide repeats 2) (eg, Charcot-Marie-Tooth disease), full gene sequence SLC9A6 (solute carrier family 9 [sodium/hydrogen exchanger], member 6) (eg, Christianson syndrome), full gene sequence SLC26A4 (solute carrier family 26, member 4) (eg, Pendred syndrome), full gene sequence SLC37A4 (solute carrier family 37 [glucose-6-phosphate transporter], member 4) (eg, glycogen storage disease type Ib), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), full gene sequence SOS1 (son of sevenless homolog 1) (eg, Noonan syndrome, gingival fibromatosis), full gene sequence SPAST (spastin) (eg, spastic paraplegia), full gene sequence SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), full gene sequence STXBP1 (syntaxin-binding protein 1) (eg, epileptic encephalopathy), full gene sequence TAZ (tafazzin) (eg, methylglutaconic aciduria type 2, Barth syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), full gene sequence TH (tyrosine hydroxylase) (eg, Segawa syndrome), full gene sequence TMEM43 (transmembrane protein 43) (eg, arrhythmogenic right ventricular cardiomyopathy), full gene sequence TNNT2 (troponin T, type 2 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TRPC6 (transient receptor potential cation							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	channel, subfamily C, member 6) (eg, focal segmental glomerulosclerosis), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), duplication/deletion analysis UBE3A (ubiquitin protein ligase E3A) (eg, Angelman syndrome), full gene sequence UMOD (uromodulin) (eg, glomerulocystic kidney disease with hyperuricemia and isosthenuria), full gene sequence VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52) WAS (Wiskott-Aldrich syndrome [eczema-thrombocytopenia]) (eg, Wiskott-Aldrich syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B) full gene sequence ASPM (asp [abnormal spindle] homolog, microcephaly associated [Drosophila]) (eg, primary microcephaly), full gene sequence CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence COL4A4 (collagen, type IV, alpha 4) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), duplication/deletion analysis COL6A1 (collagen, type VI, alpha 1) (eg, collagen type VI-related disorders), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), full gene sequence COL6A3 (collagen, type VI, alpha 3) (eg, collagen type VI-related disorders), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence KDM5C (lysine [K]-specific demethylase 5C) (eg, X-linked mental retardation), full gene sequence KIAA0196 (KIAA0196) (eg, spastic paraplegia), full gene sequence L1CAM (L1 cell adhesion molecule) (eg, MASA syndrome, X-linked hydrocephaly), full gene sequence LAMB2 (laminin, beta 2 [laminin S]) (eg, Pierson syndrome), full gene sequence MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence MYO7A (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence NPHS1 (nephrosis 1, congenital, Finnish type [nephrin]) (eg, congenital Finnish nephrosis), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence PKD1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PLCE1 (phospholipase C, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence SLC12A1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, Bartter syndrome), full gene sequence SLC12A3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, Gitelman syndrome), full gene sequence SPG11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence SPTBN2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence TMEM67 (transmembrane protein 67) (eg, Joubert syndrome), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), duplication/deletion analysis WDR62 (WD repeat domain 62) (eg, primary autosomal recessive microcephaly), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence CEP290 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, type I, alpha 2) (eg, osteogenesis imperfecta, type I), full gene sequence COL4A1 (collagen, type IV, alpha 1) (eg, brain small-vessel disease with hemorrhage), full gene sequence COL4A3 (collagen, type IV, alpha 3 [Goodpasture antigen]) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), full gene sequence DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy), full gene sequence DYSF (dysferlin, limb girdle muscular dystrophy 2B [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence ITPR1 (inositol 1,4,5-trisphosphate receptor, type 1) (eg, spinocerebellar ataxia), full gene sequence LAMA2 (laminin, alpha 2) (eg, congenital muscular dystrophy), full gene sequence LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), full gene sequence MYH11 (myosin, heavy chain 11, smooth muscle) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence NEB (nebulin) (eg, nemaline myopathy 2), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence PKHD1 (polycystic kidney and hepatic disease 1) (eg, autosomal recessive polycystic kidney disease), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence RYR2 (ryanodine receptor 2	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	[cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic right ventricular dysplasia), full gene sequence or targeted sequence analysis of > 50 exons USH2A (Usher syndrome 2A [autosomal recessive, mild]) (eg, Usher syndrome, type 2), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence							
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, part of CLFS.	☑
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Feb 2010	Archival Retrieval for Mutational Analysis	17	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Jan 2013	Optical Endomicroscopy	15	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdisection	12	CPT 2008	September 2011	Survey for January 2014 (added 88380 as part of the family).	☑
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdisection	12	CPT 2008	September 2013	Survey for January 2014 (added 88380 as part of the family).	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
88384	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88385	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
90769	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
9111X		Jan 2021	Colon Capsule Endoscopy	21	CPT 2022	January 2026		☐
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	April 2015	Liver Elastography	19	CPT 2016	January 2020	Surveyed for January 2020. Decreased.	☑
92065		Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐
920XX		Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	April 2015	Survey for October 2015. The RUC noted that it is the specialty societies decision whether 92133 and 92134 need to be surveyed with this service.	☑
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Apr 2014	Corneal Hysteresis Determination	23	CPT 2015	October 2018	Survey for January 2019.	☑
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92284		Apr 2021	Dark Adaption Eye Exam	20	CPT 2023	October 2023	The RUC will review the typical technology used to perform this service when it is next re-evaluated, acknowledging that the device included in proposed direct practice costs recently was very recently replaced with a newer technology.	☐
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Apr 2015	Arterial Pressure Waveform Analysis	20	CPT 2016	January 2022	Review in 2 years (January 2022)	☐
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	January 2023		☐
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93299	Code Deleted CPT 2020	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
933X0		Oct 2020	3D Imaging of Cardiac Structures	09	CPT 2022	January 2026		☐
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Jan 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
93982	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
93X1X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93X2X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93X3X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93X4X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93X5X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93X6X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
946X1		Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
946X2		Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Jan 2018	Electrocorticography	18	CPT 2019	January 2023		☐
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	January 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Oct 2013	HCPAC - Ultrasonic Wound Assessment	17	CPT 2015	October 2018	Survey for January 2019.	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐
989X1		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
989X2		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
989X3		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
989X4		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
989X5		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99363	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99364	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99439		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	January 2023		☐
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	January 2023		☐
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2023		☐
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2024		☐
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	Jan 2019	Chronic Care Remote Physiologic Monitoring	20	CPT 2020	January 2024		☐
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	Jan 2019	Self-Measured Blood Pressure Monitoring	19	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2022		☐
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99488	Code Deleted	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	October 2017	Code Deleted	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2015	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99491		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

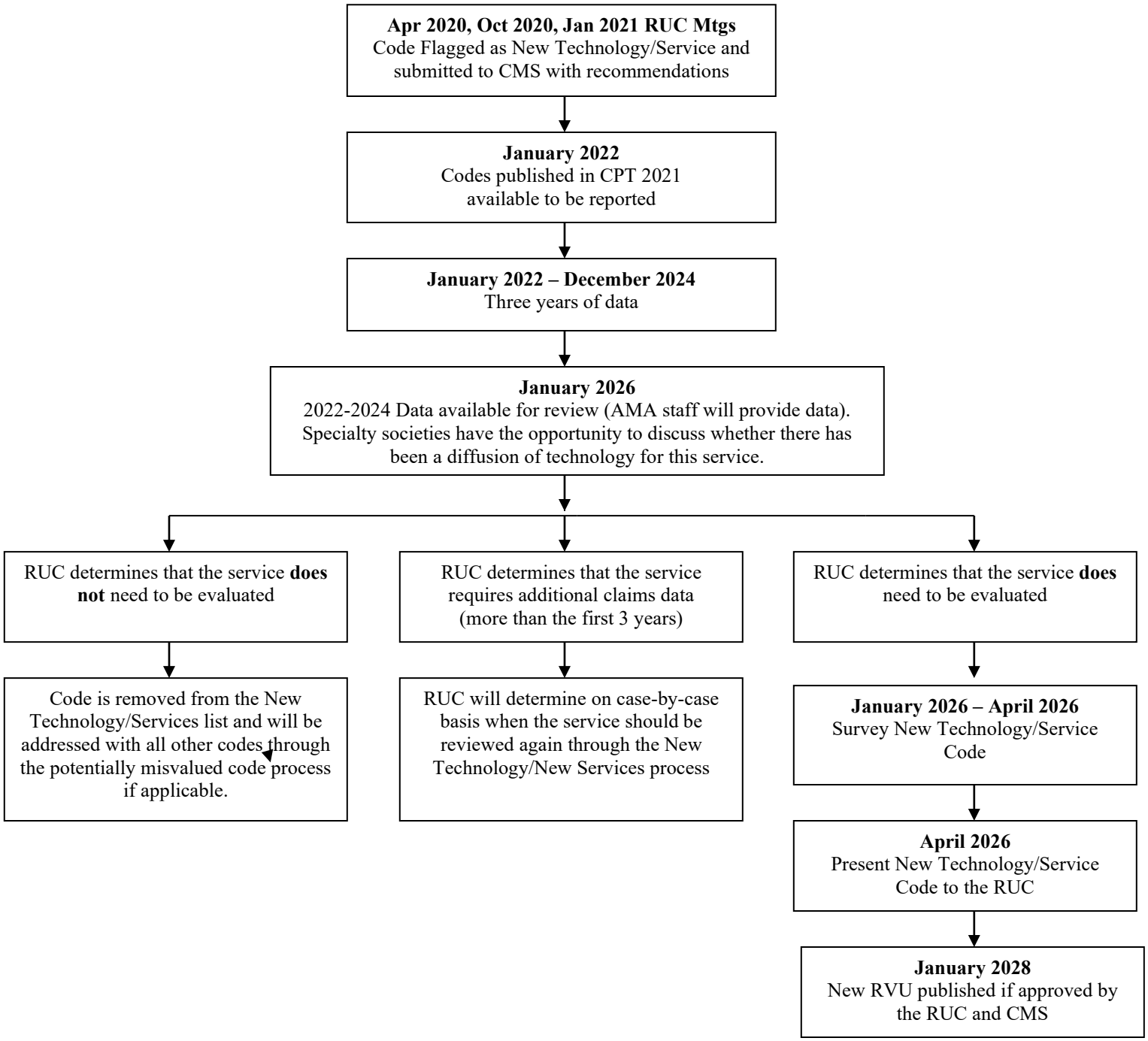
CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Jan 2014	Advance Care Planning	19	CPT 2015	January 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Jan 2014	Advance Care Planning	19	CPT 2015	January 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐
99X21		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99X22		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99X23		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99X24		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99X25		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes		Fecal Bacteriotherapy		CPT 2013	October 2018		☑

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Society	Acronym
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology Association	AADA
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Sleep Medicine	AASM
American Association for Thoracic Surgery	AATS
American Association of Clinical Endocrinologists	AACE
American Association of Clinical Urologist, Inc.	AACU
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic Medicine	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Burn Association	ABA

Society	Acronym
American Clinical Neurophysiology Society	ACNS
American College of Allergy, Asthma & Immunology	ACAAI
American College of Cardiology	ACC
American College of Chest Physicians	CHEST
American College of Emergency Physicians	ACEP
American College of Gastroenterology	ACG
American College of Medical Genetics	ACMG
American College of Mohs Surgery	ACMS
American College of Nuclear Medicine	ACNM
American College of Obstetricians and Gynecologists	ACOG
American College of Physicians	ACP
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Psychiatric Association	APA
American Rhinologic Society	ARS

Society	Acronym
American Roentgen Ray Society	ARRS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Radiation Oncology	ASTRO
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Transplantation and Cellular Therapy	ASTCT
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of Dermatopathology	ASDP
American Society of Echocardiography	ASE
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Interventional Pain Physicians	ASIPP
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS

Society	Acronym
American Society of Retina Specialists	ASRS
American Society of Transplant Surgeons	ASTS
American Thoracic Society	ATS
American Urological Association	AUA
American Vein and Lymphatic Society	AVLS
American Women's Medical Association	AWMA
Association of University Radiologists	AUR
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Heart Rhythm Society	HRS
Infectious Diseases Society of America	IDSA
International Society for the Advancement of Spine Surgery	ISASS
National Association of Medical Examiners	NAME
North American Neuromodulation Society	NANS
North American Spine Society	NASS
Obesity Medicine Association	OMA
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Hospital Medicine	SHM
Society of Interventional Radiology	SIR

Society	Acronym
Society of Laparoscopic & Robotic Surgeons	SLS
Society of Nuclear Medicine and Molecular Imaging	SNMMI
Society of Thoracic Surgeons	STS
The Endocrine Society	ES
The Society for Cardiovascular Angiography and Interventions	SCAI
The Spine Intervention Society	SIS
Underseas and Hyperbaric Medical Society	UHMS

CPT Code	Long Descriptor	Global	99204	99211	99212	99213	99214	99215	Total CY2023 CMS Proposed NPRM Physician Time - Current	Total CY2023 CMS Proposed NPRM Physician Time with RUC Proposed Office Visit Times	Change in Total Physician Time	Total CY2023 RUC Proposed Surgical Global wRVU - Before Adjustment	RUC Recommended Surgical Global wRVU After Incorporating RUC Proposal for Bundled Visits	Change in Surgical Global wRVU	Change in Clinical Staff Time
22630	Arthrodesis, posterior interbod	090				2	1		479	**500**	21	22.09	**23.17**	1.08	**-2**
22633	Arthrodesis, combined posteric	090				2	1		509	**530**	21	26.80	**27.88**	1.08	**-2**
22869	Insertion of interlaminar/inters	090			1	1			175	**182**	7	7.03	**7.58**	0.55	**0**
27446	Arthroplasty, knee, condyle and	090				2	1		310	**331**	21	17.13	**18.21**	1.08	**-2**
27447	Arthroplasty, knee, condyle and	090				3			374	**395**	21	19.60	**20.59**	0.99	**0**
69714	Implantation, osseointegrated i	090			1	2			182	**196**	14	8.69	**9.57**	0.88	**0**
69717	Revision/replacement (includin	090			1	2			187	**201**	14	8.80	**9.68**	0.88	**0**
69716	Implantation, osseointegrated i	090				2			185	**199**	14	9.77	**10.43**	0.66	**0**
69719	Revision/replacement (includin	090				2			186	**200**	14	9.77	**10.43**	0.66	**0**
69726	Removal, osseointegrated impl	090			1	1			148	**155**	7	5.93	**6.48**	0.55	**0**
69727	Removal, osseointegrated impl	090			1	1			164	**171**	7	7.13	**7.68**	0.55	**0**

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Arthrodesis Decompression – Tab 4

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A CPT coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for CPT codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, and revised definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment." In January 2021, the specialty societies surveyed the two new add-on codes and indicated that the revisions to existing codes were editorial precluding survey. The RUC disagreed and recommended that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 and 63053) be surveyed together for review at the April 2021 RUC meeting and interim values were established for CPT codes 63052 and 63053 until these two new codes could be reviewed again with the entire family in April.

22630 ***Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 22.09, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 479 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning.

The RUC noted that the total recommended time of 479 minutes is nearly identical to the total time of both the survey and the current code (487 minutes) which was initially valued in 1995. The post-operative visits have decreased by one, but the level of the visits has changed, practically resulting in a net change of zero in overall physician time despite the decrease of one visit. The RUC discussed the significant decrease in intra-service time of 30 minutes and considered crosswalk code alternatives; however, none of the crosswalk code options were deemed clinically comparable or sufficiently matched to the difficulty of the procedure. The change in time for the survey code, since it was valued in 1995, is attributed intra-operatively to the use of more effective drills, better X-rays, and several steps that streamline the procedure and make it more efficient. However, the RUC noted that while the procedure may be more efficient, it is not safer or less difficult. The elements that remain are

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intense, such that the risk of the procedure, remains the same as it was originally; therefore, the RUC agreed that the current value should be maintained.

To justify the current work RVU of 22.09, the RUC compared the survey code to the top key reference service codes 22533 *Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar* (work RVU = 24.79, 180 minutes intra-service time and 549 minutes total time) and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and noted that the majority of respondents who chose 22533 as a key reference service indicated that the intensity/complexity of 22630 is similar to or somewhat more than 22533. Also, the respondents who chose 22612 as a key reference service indicated the intensity/complexity of 22630 is more than 22612.

The RUC also compared CPT code 22630 to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time and 404 minutes total time) and 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53, 150 minutes intra-service time and 502 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation. For additional support, the RUC noted that the survey code is further bracketed by comparator codes 38720 *Cervical lymphadenectomy (complete)* (work RVU = 21.95, 150 minutes intra-service time and 482 minutes total time) and 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59, 150 minutes intra-service time and 480 minutes total time). The RUC concluded that the value of CPT code 22630 should be maintained at 22.09 work RVUs, which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 22.09 for CPT code 22630.**

22632 ***Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 5.22, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this add-on service. The RUC recommends 60 minutes of intra-service time and noted that the intraoperative time has not changed since the code was initially valued in 1995. At that time, the value of this code was calculated based on 25% of the base code.

The specialties noted that a comparison to the key reference service codes 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) might support a higher work RVU, however, there was no compelling evidence that the work had changed. The RUC agreed that work had not changed.

The RUC also compared CPT code 22632 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and

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noted that the comparator code has less intra-service and total time and is appropriately valued lower than the survey code. The specialties noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA) while, in comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same time and similar intensity: 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and 22854 *Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)* (work RVU = 5.50, 60 minutes intra-service and total time). The RUC concluded that the value of CPT code 22632 should be maintained at 5.22 work RVUs which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 5.22 for CPT code 22632.**

22633 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to MPC code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU= 26.80, 180 minutes intra-service and 442 minutes total time) which falls below the survey 25th percentile and has identical intra-service time that appropriately accounts for the total physician work involved in this service.

The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 509 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning. The RUC used a crosswalk due to the changes in visits that caused a decrease in total time, primarily due to a change in inpatient care. Previously, there were two level-3 hospital visits and one level-2 hospital visit, this has been decreased to two level-2 and one level-1 inpatient visit along with a discharge day visit causing a substantial decrease in total time for the procedure, greater than the decrease in intra-service time; thus, a crosswalk was selected rather than recommending maintaining current value. The RUC discussed the recommended crosswalk code 55866 and noted that it is recently reviewed and performed 20,000/year and places the intraoperative intensity appropriately within this family of codes.

To justify the crosswalk value of 26.80 work RVUs, the RUC compared the survey code to the top key reference service code 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes

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intra-service time and 482 minutes total time) and 2nd key reference code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13, 180 minutes intra-service time and 550 minutes total time) and noted that the physician work and total time of the survey code is appropriately bracketed between the two reference services using magnitude estimation.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh (complete)* (work RVU = 26.60, 180 minutes intra-service time and 424 minutes total time). The RUC concluded that, given changes in intra-service and total time for the procedure, CPT code 22633 should be valued based on a direct work RVU crosswalk to CPT code 55866 which falls below the survey 25th percentile and preserves rank order within the family. **The RUC recommends a work RVU of 26.80 for CPT code 22633.**

22634 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 7.96 appropriately accounts for the physician work involved in this add-on service and is less than the current value. The RUC noted that the current value for 22634 is based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. Although the current survey median work RVU would suggest an increase is warranted, the specialty did not present compelling evidence for an increase and the RUC recommends a decrease in the work RVU to account for the five minute decrease in median intra-service time. The RUC recommends 65 minutes of intra-service time as supported by the survey. The RUC noted that this service is more difficult and complex than CPT code 22632 due to the more complex patient undergoing this procedure and considerable additional steps that are not included in 22630 and 22632.

To justify a work RVU of 7.96, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the survey code has greater intra-service and total time and involves more physician work than the reference service. It was also rated as more intense/complex overall than the key reference service by 88% of survey respondents who selected the KRS. The RUC also compared CPT code 22634 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code has much less intra-service and total time and is appropriately valued lower than the survey code.

For additional support, the RUC noted that the survey code is bracketed by comparator codes 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 7.00, 60 minutes intra-service and total time) and 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone*

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angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure) (work RVU = 8.00, 60 minutes intra-service and total time). The RUC concluded that CPT code 22634 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes. **The RUC recommends a work RVU of 7.96 for CPT code 22634.**

63052 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 5.70 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 45 minutes intra-service time and noted that the time has increased by five minutes compared to the previous survey and that the recommendation is slightly higher than the interim recommendation. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. The RUC was concerned that without the base codes and add-on codes being surveyed together, that the survey for the add-on codes may have included work from the primary codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The current survey included all six codes on one survey instrument. Additionally, the overall experience of the survey respondents is greater for the new survey of six codes when compared to the prior survey of only the new add-on codes. The RUC determined that the value of 5.70 is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary. The RUC also noted that the time included in this add-on service is essentially all high-risk. The lower intensity surgical exposure activities have already been completed with the base code, so the physician work of 63052 involves is the actual higher intensity decompression as clarified by CPT.

To justify a work RVU of 5.70, the RUC compared the survey code to the top key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that the reference code has both more physician work and intra-service time and is therefore valued higher.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work, time, and intensity of 63052 is greater than 34812.

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For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) and code 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 63052 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.70 for CPT code 63052.**

63053 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic and spine surgeons and determined that the survey 25th percentile work RVU of 5.00 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 40 minutes intra-service time and noted that the time has increased by ten minutes compared to the previous survey. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The new survey, which included all six codes, elicited a time that is only five minutes less than the work related to 63052 and is believed to be a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and of an additional segment. The RUC determined that the new value is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary.

To justify a work RVU of 5.00, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the codes have the same intra-service time, but the reference code is more intense and is appropriately valued higher than the survey code using magnitude estimate. The RUC also compared the survey code to the second key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that this reference code has more physician work and intra-service time and is therefore valued higher than the survey code.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time for 63053 includes bony and soft tissue resection

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(typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work and intensity of 63053 is appropriately greater than 34812.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the similar intraoperative time and similar intensity: 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.44, 40 minutes intra-service and total time) and 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 63053 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.00 for CPT code 63053.**

Practice Expense
The Practice Expense Subcommittee removed the EQ168 *light, exam* for CPT codes 22630 and 22633. No direct practice expense inputs were recommended for the facility-only add-on codes 22632, 22634, 63052 and 63053. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Arthrodesis **Posterior, Posterolateral or Lateral Transverse Process Technique** *To report instrumentation procedures, see 22840-22855, 22859. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to spinal instrumentation codes 22840-22848, 22850, 22852, 22853, 22854, 22859.* *To report bone graft procedures, see 20930-20938. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to bone graft codes 20900-20938.* **Corpectomy** identifies removal of a vertebral body during spinal surgery. **Facetectomy** is the excision of the facet joint between two vertebral bodies. There are two facet joints at each vertebral segment (see below) **Foraminotomy** is the excision of bone to widen the intervertebral foramen. The intervertebral foramen is bordered by the superior notch of the adjacent vertebra, the inferior notch of the vertebra, the facet joint and the intervertebral disc.				

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Hemilaminectomy is removal of a portion of a vertebral lamina, usually performed for exploration of, access to, or decompression of the intraspinal contents.

Lamina pertains to the vertebral arch, the flattened posterior portion of the vertebral arch extending between the pedicles and the midline, forming the dorsal wall of the vertebral foramen, and from the midline junction of which the spinous process extends.

Laminectomy is excision of a vertebral lamina; commonly used to denote removal of the posterior arch.

Laminotomy is excision of a portion of the vertebral lamina, resulting in enlargement of the intervertebral foramen for the purpose of relieving pressure ~~in~~ on a spinal nerve root.

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae. A vertebral interspace is the nonbony compartment between two adjacent vertebral bodies which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilaginous endplates.

Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 63052, 63053.

Decompression solely to prepare the interspace for fusion is not separately reported.

(e)22600	-	Arthrodesis, posterior or posterolateral technique, single ~~level~~ interspace; cervical below C2 segment	090	17.40 (No change)
(e)22610	-	thoracic (with lateral transverse technique, when performed)	090	17.28 (No change)
(e)22612	-	lumbar (with lateral transverse technique, when performed) (Do not report 22612 in conjunction with 22630 for the same interspace ~~and segment~~, use 22633)	090	23.53 (No change)
(e)+22614	-	each additional ~~vertebral segment~~ interspace (List separately in addition to code for primary procedure) (Use 22614 in conjunction with 22600, 22610, 22612, 22630 or 22633 when performed for arthrodesis at a different ~~level~~ interspace. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace,	ZZZ	6.43 (No change)

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		use 22632. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634) (For facet joint fusion, see 0219T-0222T) (For placement of a posterior intrafacet implant, see 0219T-0222T)		
(f)22630	J1	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar (Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633)	090	22.09 (No change)
(f)+22632	J2	each additional interspace (List separately in addition to code for primary procedure) (Use 22632 in conjunction with 22612, 22630, or 22633 when performed at a different ~~level~~ interspace. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace, use 22632. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634)	ZZZ	5.22 (No change)
▲22633	J3	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace ~~and segment~~; lumbar (Do not report with 22612 or 22630 ~~at the~~ for the same ~~level~~ interspace)	090	26.80
+▲22634	J4	each additional interspace and segment (List separately in addition to code for primary procedure) (Use 22634 in conjunction with 22633)	ZZZ	7.96

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		(Do not report 22630, 22632, 22633, 22634 in conjunction with 63030, 63040, 63042, 63047, 63056, 63052, 63053, for laminectomy performed to prepare the interspace on the same spinal interspace[s]) (To report decompression performed on the same interspace as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)		

Nervous System
Posterior Extradural Laminotomy or Laminectomy for Exploration/Decompression of Neural Elements or Excision of Herniated Intervertebral Discs

Definitions

For purposes of CPT coding . . .

63020 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical*

(For bilateral procedure, report 63020 with modifier 50)

63030 *1 interspace, lumbar*
(For bilateral procedure, report 63030 with modifier 50)

+63035 *each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)*

(Use 63035 in conjunction with 63020-63030)

(Do not report 63030, 63035 in conjunction with 22630, 22632, 22633, 22634 for laminotomy performed to prepare the interspace for fusion on the same spinal interspace)

(To report decompression performed on the same interspace and vertebral segment[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

(For bilateral procedure, report 63035 twice. Do not report modifier 50 in conjunction with 63035)

(For percutaneous endoscopic approach, see 0274T, 0275T)

63040 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical*

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63042 *lumbar*
(For bilateral procedure, report 63042 with modifier 50)

+63043 *each additional cervical interspace (List separately in addition to code for primary procedure)*
(Use 63043 in conjunction with 63040)
(For bilateral procedure, report 63043 twice. Do not report modifier 50 in conjunction with 63043)

✚*63044* *each additional lumbar interspace (List separately in addition to code for primary procedure)*

(Use 63044 in conjunction with 63042)

(Do not report 63040, 63042, 63043, 63044, in conjunction with 22630, 22632, 22633, 22634 for laminotomy to prepare the interspace for fusion on the same interspace and vertebral segment[s])

(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

(For bilateral procedure, report 63044 twice. Do not report modifier 50 in conjunction with 63044)

Decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, facetectomy, or foraminotomy may be separately reported using 63052.

Codes 63052, 63053 may only be reported for decompression at the same anatomic site(s) when posterior interbody fusion (eg, 22630) requires decompression beyond preparation of the interspace(s) for fusion.

63045 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical*

63046 *thoracic*

63047 *lumbar*

✚▲63048 each additional vertebral segment, cervical, thoracic or lumbar (List separately in addition to code for primary procedure

(Use 63048 in conjunction with 63045-63047)

(Do not report 63047, 63048 in conjunction with 22630, 22632, 22633, 22634 for laminectomy performed to prepare the interspace for fusion on the same vertebral segments and/or interspace[s])

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		(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)		
+●63052	J5	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	ZZZ	5.70
+●63053	J6	each additional segment (List separately in addition to code for primary procedure) (Use 63053 in conjunction with 63052) (Use 63052, 63053 in conjunction with 22630, 22632, 22633, 22634)	ZZZ	5.00

63050 *Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;*

63051 *with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)*

Transpedicular or Costovertebral Approach for Posterolateral Extradural Exploration/Decompression

63055 *Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic*

63056 *lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)*

+63057 *each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure*

(Use 63057 in conjunction with 63055, 63056)

(Do not report 63056, 63057 for a herniated disc, in conjunction with 22630, 22632, 22633, 22634 for decompression-to prepare the interspace on the same interspace[s])

(To report decompression performed on the same interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22630 Tracking Number J1 Original Specialty Recommended RVU: **22.09**
Presented Recommended RVU: **22.09**
Global Period: 090 Current Work RVU: **22.09** RUC Recommended RVU: **22.09**

CPT Descriptor: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with a history of previous discectomy at L4-L5 presents with a spondylolisthesis and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. Arthrodesis via a unilateral or bilateral approach of L4-L5 is performed using a posterior interbody technique. (Note: Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 99% , In the ASC 1%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 13% , Overnight stay-more than 24 hours 88%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Review preoperative laboratory workup. Write preoperative orders for perioperative medications. Review MRI and/or other spinal imaging studies. Review planned incisions and procedure. Update H&P, review current medications, review surgical procedure, postoperative recovery in and out of the hospital, and the expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with the anesthesiologist. Perform preoperative time out, confirming patient identity, surgical site, procedure, indicated intraoperative medications, and antibiotic and DVT prophylaxis, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuromonitoring electrodes. Following induction of anesthesia, assist with positioning of the patient prone. Verify and/or assist with padding of the patient to prevent pressure on neurovascular structures and placement of any traction devices to facilitate intraoperative imaging. Scrub and gown. Supervise preparing and draping of the patient. Perform surgical time out.

Description of Intra-Service Work: Following skin incision, dissection is carried out through the subcutaneous tissue and fascia to the posterior spinal elements. The subcutaneous and muscular tissues are reflected to expose the posterior surface of the lamina and over the facet(s) and/or transverse processes of the segment to be fused. Verification of the levels is confirmed with imaging. Bone cutting tools are used to remove as much of the lamina above and below the facets and to remove as much of the medial edges of the facets as is necessary for adequate exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device with graft) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. The neural elements are inspected to confirm that they are free of any impingement from the implants in the canal and neuroforamen. An

interposition membrane, as by free fat graft, may be used to cover the exposed dura and nerve root. Muscles and fascia are sutured. A drain is inserted through a separate stab wound and secured. The subcutaneous tissues and skin are closed. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work:
Facility: Apply sterile dressings. Assist with repositioning patient supine. When anesthesia has been reversed, transfer the patient to the recovery room. Write an operative note in the patient's record. Monitor patient for abnormal neurological findings prior to discharge from recovery to the surgical floor. Sign the OR forms, including pre- and postoperative diagnosis and operations performed. Discuss procedure outcome with family. Dictate postoperative report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check the alignment of the lumbar spine. Later the same day, review nursing and other provider chart notes, assess patient neurovascular status and pain. Write orders or update orders, as necessary, for medications, diet, and patient activity. Chart patient progress notes. On subsequent days, examine the patient, check wounds and neurovascular status. Review nursing and other provider chart notes. Chart patient progress notes. Discuss (oral/written) patient progress with referring physician. Answer (oral/written) questions from patient and/or family, nursing and other staff, and insurance staff. When safe to discharge patient to home, conduct final exam, including neurovascular and pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing, driving, exercise) and follow-up planning with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office: Examine patient and perform neurological exam and pain assessment. Write orders for medications. Order and review periodic imaging, as appropriate. Monitor wounds and remove sutures and staples when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer patient and/or family questions and insurance staff questions. Discuss (oral/written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22630					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**10.00**	33.00	300.00	
Survey RVW:	19.60	25.00	**25.52**	28.00	35.00	
Pre-Service Evaluation Time:			**48.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	120.00	**150.00**	180.00	270.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	22630	**Recommended Physician Work RVU: 22.09**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**150.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22533	090	24.79	**RUC Time**

CPT Descriptor Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22612	090	23.53	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35301	090	21.16	**RUC Time**	35,904

CPT Descriptor 1 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32669	090	23.53	**RUC Time**	1,894

CPT Descriptor 2 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 **% of respondents:** 27.0 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 22630	**Top Key Reference CPT Code:** 22533	**2nd Key Reference CPT Code:** **22612**
Median Pre-Service Time	75.00	116.00	95.00
Median Intra-Service Time	150.00	180.00	150.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	100.0	100.00	100.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	86.0	85.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**479.00**	**549.00**	**482.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	38%	43%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	53%	40%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	7%	50%	43%

Physical effort required	3%	43%	53%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	47%	37%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	20%	52%	28%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	24%	76%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	20%	80%
Physical effort required	4%	24%	72%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	36%	64%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 22630

We recommend maintaining the current work RVU of 22.09. Although the intraoperative time decreased, the postoperative work increased and the total time is nearly identical.

Positioning time

Additional time was added to the package time of 3 minutes for supine positioning. These patients will typically be positioned prone.

Key Reference Code Comparison

KRS1: The respondents who chose 22533 as a reference indicated the intensity/complexity of 22630 is similar to somewhat more than 22533.

KRS2: The respondents who chose 22612 as a reference indicated the intensity/complexity of 22630 is more than 22612.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	0.078	479	75	150	254
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	24.79	0.076	549	116	180	253
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	23.53	0.088	482	95	150	237

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	21.16	0.104	404	75	120	209
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace;	22.09	0.078	479	75	150	254

	lumbar						
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	23.53	0.084	502	75	150	277

Other Code Comparison

Codes 38720 and 44140 bracket and offer further support of the recommended wRVU of 22.09 for 22630.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
38720	Cervical lymphadenectomy (complete)	21.95	0.075	482	75	150	257
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	0.078	479	75	150	254
44140	Colectomy, partial; with anastomosis	22.59	0.079	480	60	150	270

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22630

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,654
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 4100 Percentage 72.51 %

Specialty orthopaedic surgery Frequency 1554 Percentage 27.48 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22630

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22632 Tracking Number J2 Original Specialty Recommended RVU: **5.22**
Presented Recommended RVU: **5.22**
Global Period: ZZZ Current Work RVU: **5.22** RUC Recommended RVU: **5.22**

CPT Descriptor: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with a history of previous discectomy and posterolateral fusion of L4-L5, presents with pseudarthrosis of L4-L5, progressive spondylolisthesis of L5-S1, minimal signs of nerve root dysfunction, and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. During (separately reported) posterior lumbar interbody arthrodesis of L4-L5, he undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterior interbody technique. (Note: This is an add-on procedure. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the posterior interbody arthrodesis of the additional L5-S1 interspace.)

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Skin, muscle, and fascia incisions are extended to provide for enough retraction to safely expose the additional interspace. The ligamentum flavum and/or scar is removed from between the laminae of the additional interspace. The laminae and medial edges of the facets are removed with bone cutting instruments to a degree sufficient to allow safe exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. The neural elements are inspected to confirm that they are free of any impingement from the implant(s) in the canal and neuroforamen. An interposition membrane, as by fat graft, is applied over the exposed dura and nerve roots of the additional space. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22632					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**5.00**	20.00	300.00	
Survey RVW:	3.00	6.23	**7.48**	9.44	34.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	22.00	45.00	**60.00**	60.00	240.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22632	**Recommended Physician Work RVU: 5.22**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 23.4 **%**

Number of respondents who choose 2nd Key Reference Code: 23 **% of respondents:** 20.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 22632	Top Key Reference CPT Code: 22614	2nd Key Reference CPT Code: **22552**
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	60.00	40.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**40.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	27%	50%	23%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	31%	69%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	35%	65%

Physical effort required	8%	31%	62%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	42%	58%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	35%	57%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	39%	57%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	48%	48%
Physical effort required	0%	30%	70%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	48%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more

appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 22632

The current value for 22632 is based on a calculation in 1995 that estimated the add-on code was 25% of the primary procedure for an additional interspace. Although the current survey would suggest an increase is warranted in comparison to other similar codes, we do not have compelling evidence for an increase. Therefore, we recommend maintaining the current work RVU of 5.22. Intraoperative time has not changed.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 22632 is more/much more than 22614.

KRS2: The respondents who chose 22552 as a reference indicated the intensity/complexity of 22632 is similar/more than 22552.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	0.087	60	0	60	0
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary	4.13	0.103	40	0	40	0

	procedure)						
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	0.087	60	0	60	0

Other Code Comparison

Codes 11008 and 22854 bracket and offer further support of the recommended wRVU of 5.22 for 22632.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	5.00	0.087	60	0	60	0
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	0.087	60	0	60	0
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	5.50	0.092	60	0	60	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22632

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,875
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 1300 Percentage 69.33 %

Specialty orthopaedic surgery Frequency 575 Percentage 30.66 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22632

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22633 Tracking Number J3 Original Specialty Recommended RVU: **26.80**
Presented Recommended RVU: **26.80**
Global Period: 090 Current Work RVU: **27.75** RUC Recommended RVU: **26.80**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with a degenerative spondylolisthesis of L4-L5 causing mechanical low back pain. Non-operative treatments have failed to control her symptoms. Via unilateral or bilateral approach to the L4-L5 interspace, arthrodesis is performed using a posterolateral technique with posterior interbody technique. (Note: Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 7% , Overnight stay-more than 24 hours 93%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Review preoperative laboratory workup. Write preoperative orders for perioperative medications. Review MRI and/or other spinal imaging studies. Review planned incisions and procedure. Update H&P, review current medications, review surgical procedure, postoperative recovery in and out of the hospital, and the expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with the anesthesiologist. Perform preoperative time out, confirming patient identity, surgical site, procedure, indicated intraoperative medications, and antibiotic and DVT prophylaxis, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuromonitoring electrodes. Following induction of anesthesia, assist with positioning of the patient prone. Verify and/or assist with padding of the patient to prevent pressure on neurovascular structures and placement of any traction devices to facilitate intraoperative imaging. Scrub and gown. Supervise preparing and draping of the patient. Perform surgical time out.

Description of Intra-Service Work: Following skin incision, dissection is undertaken through the subcutaneous tissue and fascia to the posterior spinal elements. The subcutaneous and muscular tissues are reflected to expose the posterior surface of the lamina and out over the facet(s) and/or transverse processes of the segment to be fused. Verification of the levels is undertaken with imaging. Bone cutting tools are used to remove as much of the lamina above and below and as much of the medial edges of the facets as is necessary for adequate exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. Decortication of the posterolateral elements (transverse process, any remaining lamina, and/or facets) is undertaken, and graft material is packed posterolaterally to complete the arthrodesis preparations for the fusion. The neural elements are inspected to confirm that they are free of any

impingement from the implants in the canal and neuroforamen. An interposition membrane, as by free fat graft, may be used to cover the exposed dura and nerve root. Muscles and fascia are sutured. A drain is inserted through a separate stab wound and secured. The subcutaneous tissues and skin are closed. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work:
Facility: Apply sterile dressings. Assist with repositioning patient supine. When anesthesia has been reversed, transfer the patient to the recovery room. Write an operative note in the patient's record. Monitor patient for abnormal neurological findings prior to discharge from recovery to the surgical floor. Sign the OR forms, including pre- and postoperative diagnosis and operations performed. Discuss procedure outcome with family. Dictate postoperative report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check the alignment of the cervical spine. Later the same day, review nursing and other provider chart notes, assess patient neurovascular status and pain. Write orders or update orders, as necessary, for medications, diet, and patient activity. Chart patient progress notes. On subsequent days, examine the patient, check wounds and neurovascular status. Review nursing and other provider chart notes. Chart patient progress notes. Discuss (oral/written) patient progress with referring physician. Answer (oral/written) questions from patient and/or family, nursing and other staff, and insurance staff. When safe to discharge patient to home, conduct final exam, including neurovascular and pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing, driving, exercise) with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office: Examine patient and perform neurological exam and pain assessment. Write orders for medications. Order and review periodic imaging, as appropriate. Monitor wounds and remove sutures and staples when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer patient and/or family questions and insurance staff questions. Discuss (oral/written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22633					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	22.00	**40.00**	75.00	200.00	
Survey RVW:	19.00	28.00	**30.00**	32.00	48.24	
Pre-Service Evaluation Time:			**48.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	150.00	**180.00**	210.00	300.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	22633	**Recommended Physician Work RVU: 26.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22612	090	23.53	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22857	090	27.13	**RUC Time**

CPT Descriptor Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
55866	090	26.80	**RUC Time**	20,334

CPT Descriptor 1 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33641	090	29.58	**RUC Time**	1,849

CPT Descriptor 2 Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 19.8 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 18.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 22633	Top Key Reference CPT Code: 22612	2nd Key Reference CPT Code: **22857**
Median Pre-Service Time	75.00	95.00	95.00
Median Intra-Service Time	180.00	150.00	180.00
Median Immediate Post-service Time	30.00	30.00	45.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	100.0	100.00	100.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	86.0	69.00	92.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**509.00**	**482.00**	**550.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	23%	41%	36%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	23%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	23%	77%

Physical effort required	0%	23%	77%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	36%	59%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	38%	52%	10%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	38%	57%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	38%	62%
Physical effort required	0%	33%	67%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	38%	52%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 22633

We recommend crosswalking the work RVU of 26.80 for MPC code 55866 to 22633 to account for the slight decrease in intraoperative and total time. This value is less than the 25th percentile.

Positioning time

Additional time was added to the package time of 3 minutes for supine positioning. These patients will typically be positioned prone.

Key Reference Code Comparison

KRS1: The respondents who chose 22612 as a reference indicated the intensity/complexity of 22633 is more than 22612.

KRS2: The respondents who chose 22857 as a reference indicated the intensity/complexity of 22633 is similar to somewhat more than 22857.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	23.53	0.088	482	95	150	237
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	26.80	0.091	509	75	180	254
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	27.13	0.086	550	95	180	275

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	26.80	0.104	442	68	180	194
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including	26.80	0.091	509	75	180	254

	laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar						
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	0.094	562	95	164	303

Other Code Comparison

Codes 43281 and 33255 bracket and offer further support of the recommended wRVU of 26.80 for 22633.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	26.60	0.107	424	70	180	174
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	26.80	0.091	509	75	180	254
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	29.04	0.106	516	95	180	241

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22633

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 38,096
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 19800 Percentage 51.97 %

Specialty orthopaedic surgery Frequency 18286 Percentage 47.99 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22633

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22634 Tracking Number J4 Original Specialty Recommended RVU: **7.96**
Presented Recommended RVU: **7.96**
Global Period: ZZZ Current Work RVU: **8.16** RUC Recommended RVU: **7.96**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with severe disc degeneration with lateral listhesis of L4-L5 above a L5-S1 lytic or isthmic spondylolisthesis. She has significant low back pain that has not responded to non-operative treatment. During (separately reported) interbody arthrodesis of L4-L5, she undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterolateral technique with posterior interbody technique. (Note: This is an add-on service. Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the arthrodesis of the additional L5-S1 interspace.)

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Skin, muscle, and fascia incisions are extended to provide for enough retraction to safely expose the additional interspace. The ligamentum flavum and/or scar is removed from between the laminae of the additional interspace. The laminae and medial edges of the facets are removed with bone cutting instruments to a degree sufficient to allow safe exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. Decortication of the posterolateral elements (transverse process, any remaining lamina, and/or facets) is undertaken, and graft material is packed posterolaterally to complete the arthrodesis preparations for the fusion. The neural elements are inspected to confirm that they are free of any impingement from the implant(s) in the canal and neuroforamen. An interposition membrane, as by fat graft, is applied over the exposed dura and nerve roots of the additional space. (Note: Decompression of neural elements instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22634					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**25.00**	43.00	200.00	
Survey RVW:	3.50	7.96	**8.83**	10.00	36.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	24.00	48.00	**65.00**	80.00	220.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22634	**Recommended Physician Work RVU: 7.96**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**65.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 22.5 **%**

Number of respondents who choose 2nd Key Reference Code: 23 **% of respondents:** 20.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 22634	**Top Key Reference CPT Code:** 22614	**2nd Key Reference CPT Code:** **22840**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	65.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**65.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	12%	40%	44%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	20%	76%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	24%	72%
Physical effort required	4%	16%	80%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	32%	64%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	9%	22%	70%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	13%	83%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	17%	78%
Physical effort required	0%	9%	91%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	4%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 22634

The current value for 22634 is based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. Although the current survey median work RVU would suggest an increase is warranted, we do not have compelling evidence for an increase. We recommend the survey 25th percentile work RVU of 7.96 to account for the slight 5 minute decrease in median intraoperative time.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 22634 is more/much more than 22614.

KRS2: The respondents who chose 22840 as a reference indicated the intensity/complexity of 22634 is more than 22840.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.96	0.122	65	0	65	0
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular

prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.96	0.122	65	0	65	0

Other Code Comparison

The codes below bracket and offer further support of the recommended wRVU of 7.96 for 22634.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	7.00	0.117	60	0	60	0
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.96	0.122	65	0	65	0
33746	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)	8.00	0.133	60	0	60	0
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	8.00	0.133	60	0	60	0
33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	8.20	0.137	60	0	60	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22634

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 14,338
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 7900 Percentage 55.09 %

Specialty orthopaedic surgery Frequency 6438 Percentage 44.90 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22634

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63052 Tracking Number J5 Original Specialty Recommended RVU: **5.70**
Presented Recommended RVU: **5.70**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.70**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 63-year-old female with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 level, requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].)

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Following bony and soft tissue resection and exposure of the L4-5 disc space for the interbody access and preparation for interbody arthrodesis, attention is turned to the additional bone and nervous system work required for decompression beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L4 and L5 vertebral segments are removed with a drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, decompressing and mobilizing the neural elements. The neural elements are confirmed to be mobilized and decompressed. The additional intraoperative work is documented in the medical record.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63052					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	29.00	**50.00**	100.00	400.00
Survey RVW:	3.20	5.70	**6.50**	9.83	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	210.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	63052	**Recommended Physician Work RVU: 5.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22208	ZZZ	9.66	**RUC Time**

CPT Descriptor Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 24.3 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 16.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 63052	**Top Key Reference CPT Code:** 22840	**2nd Key Reference CPT Code:** **22208**
Median Pre-Service Time	0.00	22840.0	0.00
Median Intra-Service Time	45.00	60.00	120.00
Median Immediate Post-service Time	0.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**60.00**	**135.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	30%	33%	37%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	26%	74%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	26%	70%

Physical effort required	11%	26%	63%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	22%	74%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	33%	17%	22%	28%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	39%	11%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	28%	17%	56%
Physical effort required	22%	22%	56%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	17%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more

appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 63052

We recommend a work RVU of 5.70 (survey 25th percentile) and total time of 45 minutes. This RVW is higher than the interim recommendation of 5.55 which was the prior survey 25th percentile for a total time of 40 minutes.
Rationale: The RUC previously accepted the survey 25th percentile as interim, but believed the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. This new survey included all six codes. In addition, the overall experience of the survey respondents is greater for the new survey of 6 codes when compared to the prior survey of the add on codes (ie, although the median is still 50, there is a shift to the right).

Key Reference Code Comparison

KRS1: The respondents who chose 22840 as a reference indicated the intensity/complexity of 63052 is more/much more than 22840.

KRS2: The respondents who chose 22208 as a reference indicated the intensity/complexity of 63052 is overall similar to 22208.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	9.66	0.78	135	0	120	15

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0

Other Code Comparison

Codes 22585 and 22552 bracket and offer further support of the recommended wRVU of 5.70 for 63052.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	5.52	0.123	45	0	45	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 5830 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 5170 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63053 Tracking Number J6 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.00**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 and L5-S1 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 68-year-old male with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 and L5-S1 levels requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention at each level. The first segment laminectomy has been completed (separately reported) and now the additional segment is addressed. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s] of the additional segment.)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: After (separately reported) bony and soft tissue resection and exposure of the L4-L5 and L5-S1 disc spaces for the interbody access and preparation for arthrodesis is completed, along with the (separately reported) decompression of neural elements at the L4-L5 interspace, attention is turned to the additional bone and nervous system work required for decompression of the L5-S1 interspace beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L5 and S1 vertebral segments are removed with the drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, allowing for decompression and mobilization of the neural elements are mobilized. The neural elements are confirmed to be mobilized and decompressed. The additional intraoperative work is documented in the medical record.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63053					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**30.00**	70.00	400.00
Survey RVW:	3.00	5.00	**6.00**	7.38	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**40.00**	45.00	210.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	63053	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 17.1 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 63053	**Top Key Reference CPT Code:** 22614	**2nd Key Reference CPT Code:** **22840**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	40.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	21%	63%	16%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	32%	68%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	26%	74%
Physical effort required	0%	37%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	26%	74%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	32%	58%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	16%	84%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	16%	79%
Physical effort required	11%	21%	68%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	16%	79%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 , 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053 for CY 2022.

Recommendation – 63053

We recommend a work RVU of 5.00 (survey 25th percentile) and total time of 40 minutes. This RVW is higher than the interim recommendation of 4.44 which was crosswalked to code 33572 with total time = 30 minutes).
Rationale: The RUC previously crosswalked a value that was less than the survey 25th percentile based on total time as interim, but believed the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. This new survey included all six codes. In addition, the overall experience of the survey respondents is greater for the new survey of 6 codes when compared to the prior survey of the add on codes (ie, the 25th pctl, median, 75th pctl, and max 12-month experience is all greater). The new survey, which included all codes, elicited a time that is only 5 minutes less than the work related to 63052 and that we believe is a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and of an additional segment.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 63053 is more than 22614.

KRS2: The respondents who chose 22840 as a reference indicated the intensity/complexity of 63053 is more/much more than 22840.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0

Other Code Comparison

Codes 44128 and 22585 bracket and offer further support of the recommended wRVU of 5.00 for 63053.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	4.44	0.106	40	0	40	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	5.52	0.123	45	0	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 2120 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 1880 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

+63052 and +63053: Historical Reporting Overview

Coding History

In the 1990's, the work for arthrodesis and decompression was typically performed jointly by an orthopedic surgeon who would perform the arthrodesis and a neurosurgeon who would perform the decompression. Perhaps the single most important aspect of this coding was that the decompression and arthrodesis was being coded at the same spinal level. The codes were surveyed in that manner, and wRVUs were based on each surgeon's work.

In 1998, an AMA CPT workgroup that convened to discuss reporting correct coding for spine procedures via an anterior approach, also reviewed the lumbar interbody fusion code (22630) and decompression code (63047) and determined that each code may be separately and discretely performed and that there was no overlap in intra-service work. The workgroup also agreed that each code was valued based on the specific work of each code (ie, interbody fusion versus decompression). For CPT 2000, the CPT Panel introduced language into code 22630 which made this point clear: “minimal laminectomy and/or discectomy to prepare the interspace.” The spirit of that language continues to this day in the parenthetical “other than for decompression.” That particular position was reinforced in the January 2001 *CPT Assistant* where a case illustration of a patient requiring a decompression and an interbody fusion was presented and the statement made, “63047-51 should be reported in addition to the code 22630.”

In 2012, in recognition that posterolateral fusions were commonly performed along with interbody fusions, a new bundled code (22633) was established to include the work of interbody fusions (22630) and posterolateral fusions (22612) being bundled together into 22633. It is important to note that the decompression element of the operation (63047) remained a separate entity as intended by the initial valuation of that code and the inclusion of ("other than for decompression") in the code descriptor.

In 2014, confusion, both at education seminars and in print, about correct coding of the additional work of laminectomy persisted, with societies not agreeing on appropriate coding for the additional work of decompression performed concurrently with interbody fusion.

In January 2015, due to misinformed educational materials, CMS took a drastic departure from the application of the CPT codes that had been in place for decades; specifically, the evolution of the codes, the validated surveys for each of the separate codes, and valuation of separate work, by establishing NCCI edits: *"CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy…; lumbar) or 63047 (laminectomy…; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047."* [Chapter 4 of the NCCI manual]

In September 2015, the stakeholder societies conducted discussions with NCCI (CMS) about the history and valuation of codes 22630-22634. NCCI staff communicated that CMS had no intention to modify its position on these code pairs and instead recommended proposing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

Overview of CPT Assistant

After the coding changes for CPT 2000, the following CPT Assistant article was published that describes correct reporting of 22630 and 63047 for the same interspace.

January 2001 page 12
Coding Consultation
Musculoskeletal System, Surgery, 22554, 22630, 63001-63048, 63075-63078 (Q&A)

Question: The descriptors of codes 22554 and 22630 describe anterior (22554) or posterior (22630) interbody technique arthrodeses to include laminectomy, and/or diskectomy to prepare the interspace (other than for decompression). In what procedural circumstance would the 63001-63048 code(s) be reported in addition to code 22630? Similarly, in what procedural circumstance would code(s) 63075-63078 be reported in addition to code 22554?

AMA Comment
For both codes 22554 and 22630…

To report code 22554…

To report code 22630, *Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar*, in addition to code 63047-51, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*, again additional procedure(s) must have been performed. For example, in spinal procedures performed on patients having lateral lumbar stenosis, the surgeon may need to perform additional work above and beyond that described by the PLIF, including facetectomy(ies) and/or foraminotomy(ies), to adequately decompress the nerve roots. For the purpose of this example, code 63047-51 should be reported in addition to code 22630.

Regarding the issue of laterality…

To further clarify, code 22630 may also require the additional performance of a posterior fusion, which involves bone grafting and placement of posterior instrumentation. These procedures should be additionally reported. If the surgeon uses a threaded bone dowel or prosthetic device in the disk space, then code +22851 should be reported. If any other type of bone graft is performed, the appropriate bone graft code should be reported.

The anterior fusion procedure described by code 22554…

In 2016, AMA CPTA staff drafted a FAQ based on the NCCI edit that was established. The stakeholder societies were not contacted about this FAQ. If we had been contacted, we would have informed AMA staff that we were in the process of discussions with CMS about coding misinformation.

October 2016 page 11
Frequently Asked Questions: Surgery: Nervous System

Question: The procedures described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?

Answer: Codes 63047 and 22633 cannot be reported for the same interspace. However, it is appropriate to report codes 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, and 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should be appended to indicate that these are two distinct procedures.

The October 2016 FAQ added considerable coding confusion and after much effort by the stakeholder societies, including presentation of the historical information in this document, CPTA published a coding correction.

> **May 2018 page 9**
> **Coding Correction: Reporting Codes 22633 and 63047**
>
> In the Frequently Asked Questions (FAQ) section (page 11) of the October 2016 issue of CPT® Assistant, the Surgery: Nervous System answer incorrectly stated that codes 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, and 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, may not be reported for the same interspace. On further analysis of this issue, it was demonstrated that this recommendation was inconsistent with previously published CPT® Assistant advice, which is that codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.
>
> This correction aligns the coding advice with historical precedent published prior to the incorrect revisions in advice given in the October 2016 FAQ.
>
> The following is the corrected coding advice:
>
> *Surgery: Nervous System*
> Question: The procedure described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?
>
> Answer: Codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.

We appreciate that CPT recognized and corrected an errant FAQ.

Summary

Since the establishment of the CCI edits in 2015, surgeons have not been allowed to report 63047 with 22630-22634 for the same interspace. **This document is meant to explain why the current utilization for decompression at the same interspace is "zero."**

The new add-on codes respond to CMS's direction (via NCCI correspondence) that recommends establishing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

In addition to creation of the add-on codes, numerous new definitions and two instructional guidelines specify when 63052 and 63053 correctly apply:

> Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 630XX, 630X1.
>
> Decompression solely to prepare the interspace for fusion is not separately reported.

ISSUE: Arthrodesis Decompression

TAB: 4

	Review							RVW					Total	PRE			INTRA					IMMD	POST Facility				POST-Office			12 Month Svy Experience				
SOURCE	Year	CPT	DESC	Glob	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	15	14	13	12	11	MIN	25th	MED	75th	MAX
REF1	2003	22533	Arthrodesis, lateral extracavitary technique, incluc	90	30	0.076	0.045			24.79			549	58	28	30			180			30	1	3	1.0		3	1								
REF2	2005	22612	Arthrodesis, posterior or posterolateral technique,	90	25	0.088	0.049			23.53			482	60	20	15			150			30	2	1	1.0		3								
Current	1995	22630	Arthrodesis, posterior interbody technique, includi	90		0.067	0.045			22.09			487	85					180			32		3	1.0		4								
SVY	2021	22630	Arthrodesis, posterior interbody technique, includi	90	111	0.100	0.052	19.60	25.00	25.52	28.00	35.00	487	48	20	15	60	120	150	180	270	30	2	1	1.0		1	2				0	5	10	33	300
REC		22630	maintain RVW	90		0.078	0.046			22.09			479	40	20	15			150			30	2	1	1.0		1	2								
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	26	0.161	0.161			6.43			40						40																
REF2	2010	22552	Arthrodesis, anterior interbody, including disc spa	ZZZ	23	0.142	0.130			6.50			50	5					45																
Current	1995	22632	Arthrodesis, posterior interbody technique, includi	ZZZ		0.087	0.087			5.22			60						60																
SVY	2021	22632	Arthrodesis, posterior interbody technique, includi	ZZZ	111	0.125	0.125	3.00	6.23	7.48	9.44	34.00	60				22	45	60	60	240											0	1	5	20	300
REC		22632	maintain RVW	ZZZ		0.087	0.087			5.22			60						60																
REF1	2005	22612	Arthrodesis, posterior or posterolateral technique,	90	22	0.088	0.049			23.53			482	60	20	15			150			30	2	1	1.0		3								
REF2	2006	22857	Total disc arthroplasty (artificial disc), anterior app	90	21	0.086	0.049			27.13			550	60	20	15			180			45	2	1	1.0		4								
Current	2011	22633	Arthrodesis, combined posterior or posterolateral	90		0.080	0.049			27.75			565	40	18	20			200			30	2	1	1.0		3								
SVY	2021	22633	Arthrodesis, combined posterior or posterolateral	90	111	0.108	0.058	19.00	28.00	30.00	32.00	48.24	517	48	20	15	60	150	180	210	300	30	2	1	1.0		1	2				0	22	40	75	200
REC		22633	crosswalk RVW to MPC code 55866	90		0.091	0.053			26.80			509	40	20	15			180			30	2	1	1.0		1	2								
MPC	*2015*	*55866*	***Laparoscopy, surgical prostatectomy, retropubic r***	*90*		*0.104*	*0.061*			*26.80*			*442*	*33*	*20*	*15*			*180*			*30*	*1*		*1.0*		*1*	*2*								
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	25	0.161	0.161			6.43			40						40																
REF2	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	23	0.209	0.209			12.52			60						60																
Current	2011	22634	Arthrodesis, combined posterior or posterolateral	ZZZ		0.117	0.117			8.16			70						70																
SVY		22634	Arthrodesis, combined posterior or posterolateral	ZZZ	111	0.136	0.136	3.50	7.96	8.83	10.00	36.00	65				24	48	65	80	220											0	10	25	43	200
REC		22634	25th percentile	ZZZ		0.122	0.122			7.96			65						65																
REF1	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	27	0.209	0.209			12.52			60						60																
REF2	2007	22208	Osteotomy of spine, posterior or posterolateral ap	ZZZ	18	0.078	0.072			9.66			135						120			15													
SVY	2020	63052	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ	141	0.213	0.213	3.50	5.55	8.50	12.75	28.00	40				10	21	40	50	365											0	25	50	80	400
interim	2020	63052	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ		0.139	0.139			5.55			40						40																
SVY	2021	63052	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ	111	0.144	0.144	3.20	5.70	6.50	9.83	25.00	45				15	30	45	60	210											0	29	50	100	400
REC		63052	25th percentile	ZZZ		0.127	0.127			5.70			45						45																
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	19	0.161	0.161			6.43			40						40																
REF2	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	19	0.209	0.209			12.52			60						60																
SVY	2020	63053	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ	141	0.217	0.217	3.00	4.70	6.50	9.50	28.00	30				8	20	30	45	370											0	8	25	54	350
interim	2020	63053	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ		0.148	0.148			4.44			30						30																
SVY	2021	63053	Laminectomy, facetectomy, or foraminotomy (unil	ZZZ	111	0.150	0.150	3.00	5.00	6.00	7.38	25.00	40				15	30	40	45	210											0	15	30	70	400
REC		63053	25th percentile	ZZZ		0.125	0.125			5.00			40						40																

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 63052, 63053
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 04/2021

CPT Code	Long Descriptor	Global Period
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	090
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	ZZZ
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	090
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	ZZZ
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	ZZZ
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
22630	A 48-year-old male with a history of previous discectomy at L4-L5 presents with a spondylolisthesis and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. Arthrodesis via a unilateral or bilateral approach of L4-L5 is performed using a posterior interbody technique. (Note: Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.)
22633	A 68-year-old female presents with a degenerative spondylolisthesis of L4-L5 causing mechanical low back pain. Non-operative treatments have failed to control her symptoms. Via unilateral or bilateral approach to the L4-L5 interspace, arthrodesis is performed using a posterolateral technique with posterior interbody technique. (Note: Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported.)
22632	A 70-year-old male with a history of previous diskectomy and posterolateral fusion of L4-L5, presents with pseudarthrosis of L4-L5, progressive spondylolisthesis of L5-S1, minimal signs of nerve root dysfunction, and intractable back pain that improves with recumbency or

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 63052, 63053
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CPT Code	Vignette
	back bracing. Non-operative treatments have failed to control his symptoms. During (separately reported) posterior lumbar interbody arthrodesis of L4-L5, he undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterior interbody technique. (Note: This is an add-on procedure. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the posterior interbody arthrodesis of the additional L5-S1 interspace.)
22634	A 68-year-old female presents with severe disc degeneration with lateral listhesis of L4-L5 above a L5-S1 lytic or isthmic spondylolisthesis. She has significant low back pain that has not responded to non-operative treatment. During (separately reported) interbody arthrodesis of L4-L5, she undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterolateral technique with posterior interbody technique. (**Note**: This is an add-on service. Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the arthrodesis of the additional L5-S1 interspace.)
63052	During (separately reported) posterior lumbar interbody arthrodesis for L4-5 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 63-year-old female with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 level, requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention. (**Note**: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].)
63053	During (separately reported) posterior lumbar interbody arthrodesis for L4-5 and L5-S1 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 68-year-old male with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 and L5-S1 levels requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention at each level. The first segment laminectomy has been completed (separately reported) and now the additional segment is addressed. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s] of the additional segment.)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

AANS, CNS, AAOS, NASS, ISASS Advisors reviewed the current PE details and adjusted as appropriate,

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for

CPT CODE(S): 22630, 22632, 22633, 22634, 63052, 63053
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Current codes were used as references

3. Is this code(s) typically reported with an E/M service?

no

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

n/a

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

For code 22630, an exam light has been added for one visit at which the surgical wounds will be assessed and drain and suture/staple removal will occur.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms	Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
Coordinate pre-surgery services (including test results)	Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission questions.

   b. Service period (includes pre, intra and post):

Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as: Responding to patient/family questions about home activity restrictions and care of drains. Confirmation of discharge antibiotics if needed, and pain medication. Coordination with other physicians and QHPs involved in the care of the patient for transfer of records. Transitioning discharge information to the surgeon's office medical record, including medication list, correspondence and imaging or lab results pending at discharge.

   c. Post-service period:

The clinical staff work includes the standard activities involved in any E/M visit including ensuring the appropriate

supplies are available in the room, ensuring imaging and lab reports are available, rooming the patient, gowning, reviewing current medications/allergies in EHR, obtaining vital signs, assisting with wound care, coordination of care, and cleaning of the room.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

yes, SA048 and SA053

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	
DESCRIPTION	**Code**	**Unit**	**Item**	**Unit**

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 63052, 63053
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

			Qty	price
pack, post-op incision care (suture & staple)	**SA053**	**pack**		**5.63**
kit, staple removal		kit	1	
kit, suture removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

n/a

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF 031 table, power – required for **all** postop office visits
EQ168 light, exam – required for **one** postop office visit

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 63052, 63053
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**22630**		**22630**		**22633**	
3		***RUC Collaboration Website***				Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, combined posterior or posterolateral technique with posterior interbody	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**90**	**90**	**90**	**90**	**90**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0**	**216**	**0**	**197**	**0**	**180**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**60**	**0**	**60**	**0**	**60**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**12**	**0**	**12**	**0**	**12**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**144**	**0**	**125**	**0**	**108**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D				5		5		5
16	CA002		L037D				20		20		20
17	CA003		L037D				8		8		8
18	CA004		L037D				20		20		20
19	CA005		L037D				7		7		7
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
74	CA036		L037D			**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
77		**End: Patient leaves office/facility**									
78		**POST-SERVICE PERIOD**									
79		**Start: Patient leaves office/facility**									
82		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
83		99211 16 minutes	16								
84		99212 27 minutes	27								
85		99213 36 minutes	36				4		2		3
86		99214 53 minutes	53						1		
87		99215 63 minutes	63								
88	CA039		L037D			**0.0**	**144.0**	**0.0**	**125.0**	**0.0**	**108.0**

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**22630**		**22630**		**22633**	
3		***RUC Collaboration Website***				Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, combined posterior or posterolateral technique with posterior interbody	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**90**	**90**	**90**	**90**	**90**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0**	**216**	**0**	**197**	**0**	**180**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**60**	**0**	**60**	**0**	**60**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**12**	**0**	**12**	**0**	**12**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0**	**144**	**0**	**125**	**0**	**108**
96	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
97		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
98	SA048						4		3		3
99	SA052						1				
100	SA053								1		1
101											
103	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
105	EF031			Office Visits			144		125		108
106	EF014			Office Visits							108
107	EQ168			Office Visits					0		

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**22633**		**22632**		**22634**		**63052**		**63053**	
3		***RUC Collaboration Website***	Arthrodesis, combined posterior or posterolateral technique with posterior interbody		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, combined posterior or posterolateral technique with posterior interbody		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**90**	**90**	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	**0**	**197**	0	0	0	0	0	0	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0**	**60**	0	0	0	0	0	0	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0**	**12**	0	0	0	0	0	0	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0**	**125**	0	0	0	0	0	0	0	0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001			5								
16	CA002			20								
17	CA003			8								
18	CA004			20								
19	CA005			7								
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
74	CA036		**n/a**	**12**	**n/a**		**n/a**		**n/a**		**n/a**	
77		**End: Patient leaves office/facility**										
78		**POST-SERVICE PERIOD**										
79		**Start: Patient leaves office/facility**										
82		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
83		99211 16 minutes										
84		99212 27 minutes										
85		99213 36 minutes		2								
86		99214 53 minutes		1								
87		99215 63 minutes										
88	CA039		**0.0**	**125.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**22633**		**22632**		**22634**		**63052**		**63053**	
3		***RUC Collaboration Website***	Arthrodesis, combined posterior or posterolateral technique with posterior interbody		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to		Arthrodesis, combined posterior or posterolateral technique with posterior interbody		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression		Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**90**	**90**	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	**0**	**197**	0	0	0	0	0	0	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0**	**60**	0	0	0	0	0	0	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0**	**12**	0	0	0	0	0	0	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0**	**125**	0	0	0	0	0	0	0	0
96	**Supply Code**	**MEDICAL SUPPLIES**										
97		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
98	SA048			3								
99	SA052											
100	SA053			1								
101												
103	**Equipment Code**	**EQUIPMENT**										
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
105	EF031			125								
106	EF014											
107	EQ168			0								

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Drug Induced Sleep Endoscopy (DISE) – Tab 5

In October 2020, the CPT Editorial Panel created a new code to report drug induced sleep endoscopy (DISE) flexible, diagnostic. At the January 2021 RUC Meeting, the RUC requested that this service be resurveyed for the April 2021 RUC Meeting using a standard 000-day survey template.

42975 ***Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic***

The RUC reviewed the survey results from 89 otolaryngologists for CPT code 42975 and determined that the survey 25th percentile work RVU of 1.95 appropriately accounts for the physician work required to perform this service. The RUC recommends 18 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 10 minutes of immediate post-service time, and 50 minutes of total time for CPT code 42975. The specialty society noted that this procedure involves endoscopic evaluation of the upper airway for sleep apnea from the tip of the nose down to the larynx to identify the type and location of the airway obstruction and to determine specific maneuvers that would alleviate the obstruction and the effect that interventions have on the collapse. The specialty society noted that the sedation involved in this procedure mimics the conditions of sleep and that the accompanying muscle and tissue collapse of the airway make endoscopic visualization more difficult.

The RUC compared CPT code 42975 to the top key reference service CPT code 31579 *Laryngoscopy, flexible or rigid telescopic, with stroboscopy* (work RVU = 1.88, 10 minutes intra-service and 34 minutes of total time) and noted that 80 percent of survey respondents determined 42975 to be more complex than key reference service 31579 and that the recommended intra-service time and total time for 42975 support a work RVU of 1.95 in appropriate rank order compared with 31579.

The RUC also compared the survey code with CPT code 62321 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.95, 15 minutes of intra-service and 45 minutes of total time), MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 15 minutes of intra-service and 49 minutes of total time), and CPT code 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU = 1.93, 15 minutes of intra-service and 48 minutes of total time) and noted that the recommended total time and work RVU fits appropriately within this range of codes. **The RUC recommends a work RVU of 1.95 for CPT code 42975.**

Practice Expense

The Practice Expense Subcommittee affirmed the practice expense inputs from the January 2021 RUC meeting. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Respiratory System **Larynx** **Endoscopy**				
31575		*Laryngoscopy, flexible; diagnostic* *(Do not report 31575 in conjunction with 31231, unless performed for a separate condition using a separate endoscope)* (Do not report 31575 in conjunction with 31572, 31573, 31574, 31576, 31577, 31578, 42975, 43197, 43198, 92511, 92612, 92614, 92616)		
Digestive System **Pharynx, Adenoids, and Tonsils** **Other Procedures**				
●42975	M1	Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic (Do not report 42975 in conjunction with 31575, 92511) (Do not report 42975 in conjunction with 31231, unless performed for a separate condition [ie, other than sleep disordered breathing] and using a separate endoscope)	000	1.95
Medicine **Special Otorhinolaryngologic Services**				
92511		*Nasopharyngoscopy with endoscope (separate procedure)* (Do not report 92511 in conjunction with 31575, 42975, 43197, 43198) *(For nasopharyngoscopy, surgical, with dilation of eustachian tube, see 69705, 69706)*		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:42975 Tracking Number Original Specialty Recommended RVU: **1.95**
Presented Recommended RVU: **1.95**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **1.95**

CPT Descriptor: Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year old male with moderate to severe obstructive sleep apnea has been unable to tolerate positive airway pressure therapy, sleep endoscopy is performed to identify anatomic and physiologic factors contributing to his obstructive sleep apnea and the selection of non-continuous positive airway pressure (cpap) treatment options

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the level of sedation required and the approximate length of the case. Review and obtain informed consent. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned. The surgeon scrubs, gowns and preps the patient for the procedure.

Description of Intra-Service Work: The nasal passages are prepared with application of a decongestant and/or topical anesthesia. Light intravenous sedation is given, which typically is provided by a separate provider, to a point where the patient is non-responsive to verbal stimuli, has snoring or partial upper airway flow limitation, and observed oxygen desaturations. The performing physician then places a flexible endoscope through the nose and advances it to the pharynx. Endoscopic evaluation of the nasopharynx, oropharynx, hypopharynx, and larynx is performed during sleep or sedation over multiple cycles of airway narrowing and/or obstruction. The velopharynx is the term for the distal (no muscular) component of the soft palate and uvula. This is the predominant site of upper pharyngeal collapse. The physician will note the anatomic site of obstruction (velopharynx, oropharynx, tongue, epiglottis), the severity of the obstruction (non, partial, complete), and pattern of obstruction (anteroposterior, circular, lateral).The physician then repositions the patient and/or performs manipulation of the head and neck and repeat endoscopy to determine effect of body position (supine versus lateral); jaw lift, tongue protrusion, or hyoid lift on airway obstruction. A patient’s existing oral appliance (mandibular advancement device) is placed and titrated to optimal effect. In certain cases, a continuous positive airway pressure (CPAP) mask may be applied to determine sites on ongoing obstruction in regular CPAP users who fail to improve with CPAP therapy.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders,

medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	42975					
Sample Size:	3963	**Resp N:**	89			
Description of Sample:	Targeted Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	8.00	**20.00**	35.00	400.00	
Survey RVW:	1.00	1.95	**2.30**	2.75	44.00	
Pre-Service Evaluation Time:			**19.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**7.00**			
Intra-Service Time:	2.00	10.00	**15.00**	20.00	40.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	42975	**Recommended Physician Work RVU: 1.95**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

8B IV Sedation/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**28.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31579	000	1.88	**RUC Time**

CPT Descriptor Laryngoscopy, flexible or rigid telescopic, with stroboscopy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31575	000	0.94	**RUC Time**

CPT Descriptor Laryngoscopy, flexible; diagnostic

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54150	000	1.90	**RUC Time**	250

CPT Descriptor 1 Circumcision, using clamp or other device with regional dorsal penile or ring block

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62321	000	1.95	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 **% of respondents:** 33.7 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 13.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 42975	Top Key Reference CPT Code: 31579	2nd Key Reference CPT Code: **31575**
Median Pre-Service Time	25.00	14.00	14.00
Median Intra-Service Time	15.00	10.00	5.00
Median Immediate Post-service Time	10.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**50.00**	**34.00**	**24.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	20%	57%	23%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	20%	77%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	63%	33%

Physical effort required	0%	55%	45%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	27%	73%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	25%	58%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	17%	83%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	33%	67%
Physical effort required	0%	8%	82%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	17%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting new code 42975. The Panel approved the CCA and the code is now being valued by the RUC. The new code will be published in the 2022 edition of the CPT Book. The new code was then surveyed for the January 2021 RUC meeting using the 000 global template with a visit. During the January RUC meeting, it was noted that the specialty should not have been able to use the 000 template with a visit, and the RUC voted to require AAO-HNS to resurvey the code for the April 2021 meeting.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3963 members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated as one or more of the following sub-specialties: General Otolaryngology, Sleep Medicine, or Pediatric Otolaryngology.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **1.95 and 15 minutes of intra service time**, based on our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 2 and post-time package 8B due to this procedure currently being done predominantly in the hospital outpatient setting using conscious sedation.

Pre-time Package 2 Difficult Patient / Straightforward Procedure (No anesthesia care)

Evaluation Time – We are recommending 18 minutes of evaluation time which is one minute less than our median survey time, but identical to the pre-service package time.

Positioning Time – We are recommending 1 minute of positioning time which is a decrease of 4 minutes from the median survey time, but consistent with the pre-service package time for this activity.

Scrub, Dress, Wait Time – We are recommending 6 minutes of scrub, dress and wait time which is a decrease of one minute from the median survey time, but consistent with the pre-service package time for this activity.

This results in a total recommended pre time of 25 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 8B IV Sedation/ Complex Procedure

Our recommended post time is 10 minutes consistent with the survey's immediate post time of 10 minutes indicated by respondents. This is 18 minutes less than the post-package time, but consistent with our survey results for post work.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	Work RVU	Intra Time	Total Time	Most Recent RUC Review	IWPUT	2019 Medicare Utilization
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	1.80	15	43	2015-10	0.083	5631
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.80	15	45	2015-10	0.08	699990
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	1.83	15	45	2011-04	0.0829	122551
47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	000	1.84	15	52	2015-10	0.0731	1737
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	1.89	15	43	2015-10	0.089	19559
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.90	15	45	2015-10	0.0866	1995
11983	Removal with reinsertion, non-biodegradable drug delivery implant	000	1.91	15	40	2018-10	0.0938	2345

36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	000	1.93	15	48	2016-10	0.0842	26
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	1.95	15	45	2015-10	0.09	217240
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	000	2.00	15	46	2010-10	0.0918	201622
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	000	2.05	15	48	2013-10	0.0922	5383
69801	Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal	000	2.06	15	43	2010-04	0.1003	24321
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	2.09	15	49	2013-01	0.0933	323621
31577	Laryngoscopy, flexible; with removal of foreign body(s)	000	2.19	15	48	2015-10	0.1053	80
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	2.20	15	45	2015-10	0.1066	1225
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	000	2.43	15	52	2015-10	0.1153	2503
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	000	2.43	15	55	2015-10	0.1108	4008
31578	Laryngoscopy, flexible; with removal of lesion(s), non-laser	000	2.43	15	51	2015-10	0.1168	59

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31599

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 106858
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume predicted below, using the percentages of the three prior codes that were used to report the service.

Specialty Otolaryngology Frequency 106858 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,619
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This takes the percentage estimates of the three codes above which were previously used to report the service and adds the volume together that is anticipated in the new code.

Specialty Otolaryngology Frequency 35619 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Endoscopy

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31573

SS Rec Summary

ISSUE: Drug Induced Sleep Endoscopy - APRIL 2021

TAB: 5

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	31579	000	Laryngoscopy, flexible or rigid telescopic, with stroboscopy	2015	30	0.141	0.055			1.88			34	8	1	5			10			10												
2nd REF	31575	000	Laryngoscopy, flexible; diagnostic	2015	12	0.117	0.039			0.94			24	8	1	5			5			5												
Jan 2021 RUC Rec	NEW			2021 (interim rec)		0.053	0.028			1.90			68	18	1	6			15			28											
SVY	42975		Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx,		89	0.099	0.041	1.00	1.95	2.30	2.75	44.00	56	19	5	7	2	10	15	20	40	10								0	8	20	35	400
REC	42975	000	Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic			0.083	0.039			1.95			50	18	1	6			15			10												

FACILITY DIRECT PE INPUTS **CPT CODE(S):** 42975

SPECIALTY SOCIETY(IES): AAO-HNS

PRESENTER(S): R. Peter Manes, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
42975	Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
42975	A 45-year old male with moderate to severe obstructive sleep apnea has been unable to tolerate positive airway pressure therapy, sleep endoscopy is performed to identify anatomic and physiologic factors contributing to his obstructive sleep apnea and the selection of non-continuous positive airway pressure (cpap) treatment options

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, sleep medicine and pediatric otolaryngology. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   42975 is a new CPT code, therefore, reference code 31576 was selected. The reference code was chosen based on the fact that it was recently valued by the RUC by our specialty, and is also a 000 global service that is typically performed in the hospital outpatient setting.

3. Is this code(s) typically reported with an E/M service?

   No, however, a discharge management visit is typical based on the typical site of service being the hospital.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   We are recommending clinical staff pre-time above the standard for 000 globals of 0 minutes. This represents extensive use of clinical staff per the PE Subcommittee standards and is consistent with the PE approved in the January 2017 and January 2020 for otolaryngology services typically performed in the hospital setting. The rationale for this time is that staff are essential to scheduling, and completing paperwork necessary, to schedule these procedures in the facility setting. The recommendation for the new code is consistent with these recommendations and includes the standard time for clinical staff activities for endoscopy procedures time in the pre-service.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A, this is a new code. No new inputs are being requested / invoices provided.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

During the pre-service period the clinical staff are conducting the typical activities for endoscopy procedures, when performed in the facility setting. Those include: Completing pre-service diagnostic and referral forms Coordinating pre-surgery services (including test results, medical evaluations) Scheduling the space and equipment in the facility Providing pre-service education and obtaining consent Completing pre-procedure phone calls and prescriptions

   b. Service period (includes pre, intra and post):

There are no clinical staff activities during the service period.

   c. Post-service period:

During the post-service period the clinical staff call the patient to check in and see how they're doing post-procedure. They also inquire about use of CPAP post procedure.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

No supplies, only making facility recommendations at this time.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

No supplies, only making facility recommendations at this time.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

No equipment, only making facility recommendations at this time.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

No equipment, only making facility recommendations at this time.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):___42975_____**

SPECIALTY SOCIETY(IES):__AAO-HNS_____

PRESENTER(S):__R. Peter Manes, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A new code.

	A	B	D	E	F	G	H	I	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 31576**		**42975**	
3		***RUC Collaboration Website***				Laryngoscopy, flexible; with biopsy(ies)		Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**112.0**	**33.0**	**0.0**	**22.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**18.0**	**30.0**	**0.0**	**19.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**91.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**0.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001		L037D			5	5		3
16	CA002		L037D			3	10		5
17	CA003		L037D			0	5		3
18	CA004		L037D			7	7		5
19	CA005		L037D			3	3		3
20	CA006		L037D						
21	CA007		L037D						
22	CA008		L037D						
23			L037D						
26		*Other activity: please include short clinical description here and type new in*	L037D						
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009		L037D			3	0		
34	CA010		L037D			5	0		
35	CA011		L037D						
36	CA012		L037D						
37	CA013		L037D			2	0		
38	CA014		L037D						
39	CA015		L037D			5	0		
40	CA016		L037D			2	0		
41	CA017		L037D						
42			L037D						
45		*Other activity: please include short clinical description here and type new in*	L037D						
48		**Intra-service (of service period)**							
49	CA018		L037D			10	0		
50	CA019		L037D						
51	CA020		L037D						
52	CA021		L037D						
55			L037D						
56		*Other activity: please include short clinical description here and type new in*	L037D						
59		**Post-Service (of service period)**							
60	CA022		L037D			15	0		
61	CA023		L037D						
62	CA024		L037D			3	0		
63	CA025		L037D			30	0		
64	CA026		L037D			10	0		
65	CA027		L037D			3	0		
66	CA028		L037D						
67	CA029		L037D			3	0		
68	CA030		L037D						
69	CA031		L037D						
70	CA032		L037D						
71	CA033		L037D						
72	CA034		L037D						
73	CA035		L037D						
74	CA036		L037D			**n/a**		**n/a**	
75			L037D						
78		*Other activity: please include short clinical description here and type new in*	L037D						
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037		L037D			3	3		3
85	CA038		L037D						
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16						
88		99212 27 minutes	27						
89		99213 36 minutes	36						
90		99214 53 minutes	53						
91		99215 63 minutes	63						
92	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**
93			L037D						
96		*Other activity: please include short clinical description here and type new in*	L037D						
99		**End: with last office visit before end of global period**							

	A	B	D	E	F	G	H	I	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 31576**		**42975**	
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5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**112.0**	**33.0**	**0.0**	**22.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**18.0**	**30.0**	**0.0**	**19.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**91.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**0.0**	**3.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**
102	SA041					1			
103	SA048					1			
104	SB012					1			
105	SB022					1			
106	SC029					1			
107	SC057					1			
108	SD009					1			
109	SD122					1			
110	SD132					2			
111	SD318					1			
112	SG056					1			
113	SH050					2			
114	SJ010					1			
115	SJ037					1			
116	SJ053					2			
117	SK058					2			
118	SL036					1			
119	SL037					1			
120	SM001					1			
121	SM010					2			
122	SM014					2			
123	SM015					4			
124	SM018					4			
125	SM019					1			
126		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
128	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
129		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**
130	ES084			Scope		57	0		
131	ES031			Scope Systems		30	0		
132	ES005			Default		30	0		
133	EQ234			Default		96	0		
134	EQ170			Default		96	0		
135	EQ167			Default		30	0		
136	EQ137			Instrument Packs		37	0		
137	EF015			Default		96	0		
138	EF008			Default		96	0		
139									
140									
141									
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

	A	B	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**							
2								
3		***RUC Collaboration Website***						
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAO-HNS**						
5		**LOCATION**						
6		**GLOBAL PERIOD**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**						
8		**TOTAL CLINICAL STAFF TIME**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**						
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**						
13		**PRE-SERVICE PERIOD**						
14		**Start: Following visit when decision for surgery/procedure made**						
15	CA001							
16	CA002							
17	CA003							
18	CA004							
19	CA005							
20	CA006							
21	CA007							
22	CA008							
23								
26		*Other activity: please include short clinical description here and type new in*						
29		**End: When patient enters office/facility for surgery/procedure**						
30		**SERVICE PERIOD**						
31		**Start: When patient enters office/facility for surgery/procedure:**						
32		**Pre-Service (of service period)**						
33	CA009							
34	CA010							
35	CA011							
36	CA012							
37	CA013							
38	CA014							
39	CA015							
40	CA016							
41	CA017							
42								
45		*Other activity: please include short clinical description here and type new in*						
48		**Intra-service (of service period)**						
49	CA018							
50	CA019							
51	CA020							
52	CA021							
55								
56		*Other activity: please include short clinical description here and type new in*						
59		**Post-Service (of service period)**						
60	CA022							
61	CA023							
62	CA024							
63	CA025							
64	CA026							
65	CA027							
66	CA028							
67	CA029							
68	CA030							
69	CA031							
70	CA032							
71	CA033							
72	CA034							
73	CA035							
74	CA036							
75								
78		*Other activity: please include short clinical description here and type new in*						
81		**End: Patient leaves office/facility**						
82		**POST-SERVICE PERIOD**						
83		**Start: Patient leaves office/facility**						
84	CA037							
85	CA038							
86		***Office visits: List Number and Level of Office Visits***						
87		99211 16 minutes						
88		99212 27 minutes						
89		99213 36 minutes						
90		99214 53 minutes						
91		99215 63 minutes						
92	CA039							
93								
96		*Other activity: please include short clinical description here and type new in*						
99		**End: with last office visit before end of global period**						

	A	B	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**							
2								
3		***RUC Collaboration Website***						
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAO-HNS**						
5		**LOCATION**						
6		**GLOBAL PERIOD**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**						
8		**TOTAL CLINICAL STAFF TIME**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**						
100	**Supply Code**	**MEDICAL SUPPLIES**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**						
102	SA041							
103	SA048							
104	SB012							
105	SB022							
106	SC029							
107	SC057							
108	SD009							
109	SD122							
110	SD132							
111	SD318							
112	SG056							
113	SH050							
114	SJ010							
115	SJ037							
116	SJ053							
117	SK058							
118	SL036							
119	SL037							
120	SM001							
121	SM010							
122	SM014							
123	SM015							
124	SM018							
125	SM019							
126		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*						
128	**Equipment Code**	**EQUIPMENT**						
129		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**						
130	ES084							
131	ES031							
132	ES005							
133	EQ234							
134	EQ170							
135	EQ167							
136	EQ137							
137	EF015							
138	EF008							
139								
140								
141								
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*						

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Transcutaneous Passive Implant-Temporal Bone – Tab 6

In October 2020, the CPT Editorial Panel revised two codes to replace "temporal bone" with "skull" and delete "or transcutaneous" and "cochlear stimulator: without mastoidectomy" from the descriptors. The Panel also replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

At the January 2021 RUC Meeting, the RUC reviewed these services and determined that they need to be resurveyed for the April 2021 RUC Meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically the lower end of the RVU spectrum. The specialty society submitted a letter to the RUC requesting that this service be referred to CPT in May 2021 to clarify the percutaneous implant removal by describing the procedure as removal of the entire implant, add a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit and to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex. The specialty society will survey these codes for the October 2021 RUC Meeting.

The RUC recommends affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Auditory System **Middle Ear** **Osseointegrated Implants** The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other reparative middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately when performed.				

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▲69714	U1	Implantation, osseointegrated implant, ~~temporal bone~~ skull;~~,~~ with percutaneous attachment to external speech processor~~/cochlear stimulator; without mastoidectomy~~	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 8.69)
●69716	U2	with magnetic transcutaneous attachment to external speech processor	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 9.77)
~~69715~~	-	~~with mastoidectomy~~ (69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	~~N/A~~
▲69717	U3	Revision/~~R~~replacement (including removal of existing device), osseointegrated implant, ~~temporal bone,~~ skull; with percutaneous attachment to external speech processor~~/ cochlear stimulator; without mastoidectomy~~	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 8.80)
●69719	U4	with magnetic transcutaneous attachment to external speech processor	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 9.77)

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~~69718~~	-	~~with mastoidectomy~~ (69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	~~N/A~~
●69726	U5	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 5.93)
●69727	U6	with magnetic transcutaneous attachment to external speech processor	090	Refer to CPT May 2021/ Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 7.13)

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AMERICAN ACADEMY OF
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HEAD AND NECK SURGERY®

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February 9, 2021

Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

RE: Referral of Transcutaneous Passive Implant – Temporal Bone family of codes (CPT 69714, 69717, 69716, 69719, 69726, and 69727) to the CPT Editorial Panel

Dear Dr. Silva,

On behalf of the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), we would like to respectfully request that the Transcutaneous Passive Implant – Temporal Bone family of codes (CPT 69714, 69717, 69716, 69719, 69726, and 69727) be referred to the CPT Editorial Panel for the May 2021 meeting. As you know, these codes were surveyed and presented to the RUC for valuation at the January 2021 meeting. After a lengthy facilitation meeting, it was determined that there was an issue with the survey responses for at least one code in the family, due to resulting rank order anomalies in intra-service time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting.

The Academy agreed with this recommendation, and indicated our intent to resurvey for the April meeting in the recently released LOIs. After discussing the possible issues with the survey responses with Academy leadership, as well as our otology colleagues and sister-societies, we believe there may be problems with the way the code family was revised at CPT in October 2020, resulting in the anomalous survey responses. Specifically, the 69726 code survey, removal of the percutaneous device, created a rank order anomaly. We discussed this dilemma with representatives from American Otological Society (AOS)/American Neurotology Society (ANS) and determined that the variation in the removal of the percutaneous device, 69726, was likely due to misinterpretation of the descriptor.

A frequent clinical scenario that occurs in removing the percutaneous device is that the implant is not truly removed. Very commonly with percutaneous

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implant wound problems, an appendage to the implant, known as the bone anchored implant abutment, which is the component that traverses the scalp, is simply uncoupled from the implant in the office setting. The resulting wound is subsequently left to heal by primary intention. The intent of CPT 69726 is for total removal of the implant and abutment which requires an operative environment and, most commonly, an otologic drill. Therefore, we are submitting a CCA that clarifies the percutaneous implant removal by describing the procedure as removal of the entire implant and have added a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit.

Additionally, there is variation in the method of transcutaneous implant placement, and we noted problems with the distribution of the intraservice times in the 69716 code that is intended to report this procedure. Discussion with the AOS/ANS leadership revealed that there are different techniques that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. We have chosen to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex as an effort to clarify the intraservice work for CPT
69716. Mirroring replacement and removal codes are also being proposed.

Given this additional information, we think it best to refer the family back to the CPT Editorial Panel for further clarification prior to resurvey. ***We therefore, request that the RUC approve referral of the family to CPT at the next opportunity in May 2021, and allow resurvey of the revised code set at the October 2021 RUC meeting.***

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Thank you in advance for your consideration of this request. If you have any questions, please contact Jenna Minton, AAO-HNS RUC staff, at jenna@proactivestrategies.net or 517.927.8696.

Sincerely,



R. Peter Manes, MD
AAO-HNS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Transcutaneous Passive Implant-Temporal Bone – Tab 18

In October 2020, the CPT Editorial replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

69714 ***Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 73 physicians and determined that a work RVU of 8.69 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 40 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69, intra-service time of 40 minutes and 197.5 minutes of total time) and noted that both codes have identical intra-service time, similar total time, and should be valued identically. The RUC agreed that due to the lack of 090-day global codes with 40 minutes of intra-service time, CPT code 52400 is an appropriate crosswalk for the work value, resulting in a work intensity that closely aligns with the revision/replacement of implant code 69717 (0.110 and 0.100 IWPUT respectively). The RUC agreed that code 52400 and the survey code have similar intra-service and total times and should be valued identically, below the survey's 25th percentile. **The RUC recommends an interim work RVU of 8.69 for CPT code 69714.**

69716 ***Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 67 physicians and determined that a work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60, immediate post service time of 15 minutes and total time of 207 minutes) and noted that both codes have identical intra-service time, identical post-service time and similar total time, and should be valued identically. The RUC agreed that an IWPUT of 0.100 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69716 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior*

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colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed (work RVU = 10.08 and total time of 211 minutes), further supporting a recommended work RVU of 9.77 for code 69716. **The RUC recommends an interim work RVU of 9.77 for CPT code 69716.**

69717 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 64 physicians and determined that a work RVU of 8.80 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 27829 *Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed* (work RVU= 8.80 and intra-service time of 45 minutes) to appropriately account for the physician work involved in this service. The RUC agreed that code 27829 is an appropriate crosswalk, the recommended work value of 8.80 for the survey code results in an IWPUT of 0.100. Additionally, the RUC agreed that the survey code should be valued identically to code 27829 because both services have identical intra-service time. **The RUC recommends an interim work RVU of 8.80 for CPT code 69717.**

69719 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, intra-service time of 60 minutes and total time of 207 minutes). The RUC agreed that the crosswalk to MPC code 50590 and recommended work value of 9.77 appropriately accounts for the physician work involved in this service because both codes have identical intra-service time, identical post-service time and similar total time. The RUC agreed that an IWPUT of 0.099 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69719 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08 and total time of 211 minutes), further warranting a recommended work RVU of 9.77 for code 69719. **The RUC recommends an interim work RVU of 9.77 for CPT code 69719.**

69726 ***Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
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The RUC reviewed the survey results from 66 physicians and determined that the work RVU of 5.93 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 5.93, intra-service time of 30 minutes and total time of 142 minutes). The RUC agreed that the work value of 5.93 appropriately accounts for the physician work involved in this service. The RUC noted that the survey code and crosswalk code 53852 have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.088 is appropriate and that the recommended work value of 5.93 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 5.93 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family. **The RUC recommends an interim work RVU of 5.93 for CPT code 69726.**

69727 ***Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 7.13 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 37718 *Ligation, division, and stripping, short saphenous vein* (work RVU = 7.13, intra-service time of 45 minutes and total time of 178 minutes). The RUC agreed that the crosswalk to code 37718 and recommended value of 7.13 appropriately accounts for the physician work involved in this service because the survey code and crosswalk code have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.085 is appropriate and is like (removal) code 69726 (IWPUT = 0.088) in the family, therefore the recommended work value of 7.13 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 7.13 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family.

The RUC agreed that the recommended work value of 7.13 is appropriately bracketed by codes 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, intra-service time of 45 minutes and total time of 161 minutes) and 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, intra-service time of 45 minutes and total time of 185 minutes). **The RUC recommends an interim work RVU of 7.13 for CPT code 69727.**

Resurvey for April 2021 RUC Meeting
In January 2021, the RUC reviewed these services and determined that they need to be interim and resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically relative values on the lower end of the spectrum. Additionally, there was concern from the specialty that survey respondents may not have fully understood the new removal codes based on the anomalous intra-service time response for code 69726 which was less than all other codes in the family.

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Practice Expense
The Practice Expense Subcommittee replaced one SA053 *pack, post-op incision care (suture and staple)* with one SA054 *pack, post-op incision care (suture)*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Auditory System** **Middle Ear** **Osseointegrated Implants** The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other reparative middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately when performed.				
▲69714	U1	Implantation, osseointegrated implant, ~~temporal bone~~ skull;~~,~~ with percutaneous attachment to external speech processor~~/cochlear stimulator; without mastoidectomy~~	090	8.69 (Interim) (Resurvey for April 2021)
●69716	U2	with magnetic transcutaneous attachment to external speech processor	090	9.77 (Interim) (Resurvey for April 2021)
~~69715~~	-	~~with mastoidectomy~~	~~090~~	N/A

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		(69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)		

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▲69717	U3	Revision/~~R~~replacement (including removal of existing device), osseointegrated implant, ~~temporal bone,~~ skull; with percutaneous attachment to external speech processor~~/ cochlear stimulator; without mastoidectomy~~	090	8.80 (Interim) (Resurvey for April 2021)
●69719	U4	with magnetic transcutaneous attachment to external speech processor	090	9.77 (Interim) (Resurvey for April 2021)
~~69718~~	-	~~with mastoidectomy~~ (69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	N/A
●69726	U5	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090	5.93 (Interim) (Resurvey for April 2021)
●69727	U6	with magnetic transcutaneous attachment to external speech processor	090	7.13 (Interim) (Resurvey for April 2021)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69714 Tracking Number Original Specialty Recommended RVU: **11.00**
Presented Recommended RVU: **8.69**
Global Period: 090 Current Work RVU: **14.45** RUC Recommended RVU: **8.69**

CPT Descriptor: Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. He is unalbe to wear traditional hearing aids. Implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 49% , In the ASC 49%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the bolster in place and with appropriate pressure.

Description of Post-Service Work: The prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69714					
Sample Size:	533	**Resp N:**	73			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**8.00**	12.00	45.00
Survey RVW:		1.00	11.00	**12.00**	14.00	17.40
Pre-Service Evaluation Time:				**34.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		10.00	25.00	**40.00**	46.00	155.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69714	**Recommended Physician Work RVU: 8.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 19.1 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 19.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 69714	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **31610**
Median Pre-Service Time	46.00	72.00	60.00
Median Intra-Service Time	40.00	75.00	45.00
Median Immediate Post-service Time	15.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	173.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	62.0	62.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**182.00**	**258.00**	**367.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	36%	36%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	29%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	21%	36%	43%
Physical effort required	29%	36%	36%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	24%	43%	36%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	21%	50%	14%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	64%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	21%	36%	43%
Physical effort required	31%	54%	16%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	50%	8%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #2

We recognize that KRS code 2, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service, that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.69 and 40 minutes of intra service time**, based on a crosswalk to CPT 52400. This is below the survey's 25th percentile.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that three post-operative office visits are typically conducted after the procedure. Two level three office visits, 99213; and one level two office visit, 99212.

Post op visit 1: 99213

The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	090	0.06	6.39	40	187	2009-04	COLORECTAL SURGERY (PROCTOLOGY)	39
59870	Uterine evacuation and curettage for hydatidiform mole	090	0.0084	6.57	40	256	2000-08	OBSTETRICS/GYNECOLOGY	4
24358	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open	090	0.0669	6.66	40	193	2007-04	ORTHOPEDIC SURGERY	664
25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	0.0632	6.94	40	191	2006-04	HAND SURGERY	268
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	090	0.0461	7.03	40	220	2007-02	ORTHOPEDIC SURGERY	216
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	090	0.0637	7.03	40	194	2011-04	ORTHOPEDIC SURGERY	51597
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive	090	0.126	8.69	40	197.5	2008-04	UROLOGY	115

	hypertrophic mucosal folds								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 279
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 279 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 93 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The current 2019 volume indicated by the RUC database for this code is 993 cases, however, we anticipate the majority of this volume (94% or so) will transfer to the new X codes.

Specialty Otolaryngology Frequency 93 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69714

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69716 Tracking Number Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **9.77**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **9.77**

CPT Descriptor: Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with left mixed hearing loss seeks intervention for improved quality of life at work and socially. Placement of a magnetic transcutaneous bone anchored heraing device is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 49% , In the ASC 49%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and a subpericranial pocket for the implant coil and magnet are created. The area for the transducer is then identified using the template and marked on the outer table of the skull in the region of the sinodural angle. Surgical guide and fixation holes are then drilled taking care not to penetrate the sigmoid sinus or the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull overlying the sinodural angle is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura and sigmoid sinus. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69716					
Sample Size:	533	**Resp N:**	67			
Description of Sample:	Targeted, random survey of 533 otolaryngologist members of the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society)					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**4.00**	10.00	30.00
Survey RVW:		1.00	12.00	**13.00**	15.39	25.00
Pre-Service Evaluation Time:				**32.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		10.00	40.00	**60.00**	70.00	159.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69716	**Recommended Physician Work RVU: 9.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**32.00**	**33.00**	**-1.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15730	090	13.50	**RUC Time**

CPT Descriptor Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57288	090	12.13	**RUC Time**	25,452

CPT Descriptor 1 Sling operation for stress incontinence (eg, fascia or synthetic)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	54

CPT Descriptor 2 Repair of traumatic corporeal tear(s)

Other Reference CPT Code	Global	Work RVU	Time Source
27279	090	12.13	**RUC Time**

CPT Descriptor Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 6.0 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 8.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 69716	Top Key Reference CPT Code: 31610	2nd Key Reference CPT Code: **15730**
Median Pre-Service Time	45.00	6960.00	58.00
Median Intra-Service Time	60.00	45.00	90.00
Median Immediate Post-service Time	15.00	20.00	17.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	173.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	69.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**185.00**	**367.00**	**255.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	8%	0%	58%	17%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	58%	34%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	42%	50%
Physical effort required	0%	75%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	33%	25%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	33%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	50%	33%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	50%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #2

We recognize that KRS code 2, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **9.77 and 60 minutes of intra service time**, based on a crosswalk to CPT 50590. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 32 minutes of evaluation time which is 1 minute less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Regarding post-operative visits, our survey respondents indicated that two post-operative visits were needed, two 99213 visits. Our expert panel agreed.

Post op visit 1: 99213

The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	090	0.0523	9.56	60	275	2006-02	ORTHOPEDIC SURGERY	9419
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	090	0.0551	9.56	60	277	2015-04	ORTHOPEDIC SURGERY	1150
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	090	0.0485	9.58	60	254	2014-01	OPHTHALMOLOGY	594
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	0.0503	9.65	60	281	2007-02	ORTHOPEDIC SURGERY	242
29906	Arthroscopy, subtalar joint, surgical; with debridement	090	0.0662	9.65	60	244	2007-04	ORTHOPEDIC SURGERY	139
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	0.0507	9.67	60	281	2007-02	ORTHOPEDIC SURGERY	423
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	0.0357	9.71	60	308	2007-02	ORTHOPEDIC SURGERY	125
50590	Lithotripsy, extracorporeal shock wave	090	0.0908	9.77	60	207	2012-04	UROLOGY	54658
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	090	0.0613	9.78	60	262	2008-04	OTOLARYNGOLOGY	518
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	090	0.0533	9.90	60	281	2005-08	PLASTIC AND RECONSTRUCTIVE SURGERY	13549
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	090	0.0812	10.00	60	228	2013-01	ORTHOPEDIC SURGERY	103

57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	9026
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	8757
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	0.0934	10.13	60	216	2007-02	GENERAL SURGERY	62740
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	090	0.0947	10.13	60	218	2016-01	GENERAL SURGERY	28
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	090	0.0648	10.14	60	279	2007-04	ORTHOPEDIC SURGERY	208
23430	Tenodesis of long tendon of biceps	090	0.0842	10.17	60	237	2009-10	ORTHOPEDIC SURGERY	19997
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	090	0.0528	10.41	60	288	2005-08	DERMATOLOGY	13328
44950	Appendectomy;	090	0.0778	10.60	60	252	2000-08	GENERAL SURGERY	1101
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	0.0426	10.70	60	323	2007-02	ORTHOPEDIC SURGERY	1662
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	090	0.0198	10.78	60	384	2007-04	ORTHOPEDIC SURGERY	1248
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	090	0.0943	11.00	60	243	2009-04	NEUROSURGERY	2414
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	0.0484	11.10	60	328	2007-02	ORTHOPEDIC SURGERY	174
41120	Glossectomy; less than one-half tongue	090	0.0715	11.14	60	278	2005-08	OTOLARYNGOLOGY	2232
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	0.0942	11.15	60	239	2010-10	OBSTETRICS/GYNECOLOGY	1737
65850	Trabeculotomy ab externo	090	0.1109	11.39	60	233	2005-08	OPHTHALMOLOGY	620
54437	Repair of traumatic corporeal tear(s)	090	0.0872	11.50	60	264	2015-01	UROLOGY	54
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	090	0.0923	11.60	60	267	2007-04	OBSTETRICS/GYNECOLOGY	986

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2979
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2019 volume for 69714 in the AMA RUC database

Specialty Otolaryngology Frequency 2979 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe the majority (94% or so) of existing volume for the predecessor code 69714 will move to this new code. Volume for 69714 in 2019 was 993 cases.

Specialty Otolarngology Frequency 900 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69717 Tracking Number Original Specialty Recommended RVU: **11.48**
Presented Recommended RVU: **8.80**
Global Period: 090 Current Work RVU: **15.43** RUC Recommended RVU: **8.80**

CPT Descriptor: Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. The device is removed and a new device is placed at a different site.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 48% , In the ASC 50%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A subpericranial dissection is performed and the previous implant abutment is removed. The cranial bone surrounding the osseointegrated titanium fixture in the patient's skull is drilled around the implant. The fixture is removed. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The area for the new placement of the implant is then identified, templated, and marked on the outer table of the skull. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A new pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal

thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the small abutment bolster in place and with appropriate pressure.

Description of Post-Service Work: he prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69717					
Sample Size:	533	**Resp N:**	64			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	10.00	11.48	**12.50**	14.00	25.00	
Pre-Service Evaluation Time:			**37.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	10.00	30.00	**45.00**	60.00	201.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69717	**Recommended Physician Work RVU: 8.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	19.00	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	62.00	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15260	090	11.64	**RUC Time**

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 14.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 14.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 69717	Top Key Reference CPT Code: 15260	2nd Key Reference CPT Code: **15120**
Median Pre-Service Time	46.00	28.00	72.00
Median Intra-Service Time	45.00	100.00	75.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	62.0	115.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**187.00**	**273.00**	**258.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	22%	67%	11%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	66%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	11%	22%	67%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	56%	44%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	11%	0%	33%	44%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	33%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	22%	44%
Physical effort required	44%	33%	22%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	33%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.80 and 45 minutes of intra service time**, based on a crosswalk to CPT 27829. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that three post-operative office visits are typically conducted after the procedure. Three level three office visits, 99213. Our expert panel agreed that three visits are necessary, but amended them to two level three visits (99213) and one level two office visit (99212) consistent with code 69714.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization	2019 Medicare Allowed Charges
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516	1560949
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173	1544895
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015	1262949
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833	430830
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199	110926
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628	3853250
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593	1406921
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674	4894644
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957	7907614

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 18
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 18 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The current 2019 volume indicated by the RUC database for this code is 68, however, we esitmate that only about 7% of existing cases will be reported in the future by the percutaneous codes. We anticipate that the remainder of the volume will transition to the new transcutaneous codes.

Specialty Otolaryngology Frequency 6 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69717

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69719 Tracking Number Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **9.77**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **9.77**

CPT Descriptor: Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed and a new device is placed at a different site.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 47% , In the ASC 51%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential repeat post-surgical skin breakdown, pain, and possible implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed NEW implant recipient site is precisely measured and then marked using the implant template. The incision is injected with local anesthetic

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is removed. The wound is thoroughly inspect for the cause of the patient's original complication related to the implant. A subpericranial pocket for the implant coil and magnet are created. The area for the new placement of the transducer is then identified using the template and marked on the outer table of the skull. Surgical guide and fixation holes are then drilled taking care not to penetrate the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69719					
Sample Size:	533	**Resp N:**	59			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	10.15	12.00	**13.00**	15.48	27.00	
Pre-Service Evaluation Time:			**37.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	14.00	43.00	**60.00**	80.00	201.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69719	**Recommended Physician Work RVU: 9.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15730	090	13.50	**RUC Time**

CPT Descriptor Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57288	090	12.13	**RUC Time**	25,452

CPT Descriptor 1 Sling operation for stress incontinence (eg, fascia or synthetic)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	54

CPT Descriptor 2 Repair of traumatic corporeal tear(s)

Other Reference CPT Code	Global	Work RVU	Time Source
27279	090	12.13	**RUC Time**

CPT Descriptor Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 13.5 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 11.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 69719	Top Key Reference CPT Code: 31610	2nd Key Reference CPT Code: **15730**
Median Pre-Service Time	46.00	60.00	58.00
Median Intra-Service Time	60.00	45.00	90.00
Median Immediate Post-service Time	15.00	20.00	17.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	173.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	69.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**186.00**	**367.00**	**255.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	38%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	63%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	13%	88%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	75%	13%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	57%	14%	29%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	57%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	57%	43%
Physical effort required	0%	71%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	43%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #1

We recognize that KRS code 1, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of 9.77 **and 60 minutes of intra service time**, based on a crosswalk to CPT 50590. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. Two level three office visits, 99213.

Post op visit 1: 99213

The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	090	0.0523	9.56	60	275	2006-02	ORTHOPEDIC SURGERY	9419
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	090	0.0551	9.56	60	277	2015-04	ORTHOPEDIC SURGERY	1150
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	090	0.0485	9.58	60	254	2014-01	OPHTHALMOLOGY	594
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	0.0503	9.65	60	281	2007-02	ORTHOPEDIC SURGERY	242
29906	Arthroscopy, subtalar joint, surgical; with debridement	090	0.0662	9.65	60	244	2007-04	ORTHOPEDIC SURGERY	139
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	0.0507	9.67	60	281	2007-02	ORTHOPEDIC SURGERY	423
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	0.0357	9.71	60	308	2007-02	ORTHOPEDIC SURGERY	125
50590	Lithotripsy, extracorporeal shock wave	090	0.0908	9.77	60	207	2012-04	UROLOGY	54658
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	090	0.0613	9.78	60	262	2008-04	OTOLARYNGOLOGY	518
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	090	0.0533	9.90	60	281	2005-08	PLASTIC AND RECONSTRUCTIVE SURGERY	13549
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	090	0.0812	10.00	60	228	2013-01	ORTHOPEDIC SURGERY	103

57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	9026
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	8757
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	0.0934	10.13	60	216	2007-02	GENERAL SURGERY	62740
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	090	0.0947	10.13	60	218	2016-01	GENERAL SURGERY	28
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	090	0.0648	10.14	60	279	2007-04	ORTHOPEDIC SURGERY	208
23430	Tenodesis of long tendon of biceps	090	0.0842	10.17	60	237	2009-10	ORTHOPEDIC SURGERY	19997
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	090	0.0528	10.41	60	288	2005-08	DERMATOLOGY	13328
44950	Appendectomy;	090	0.0778	10.60	60	252	2000-08	GENERAL SURGERY	1101
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	0.0426	10.70	60	323	2007-02	ORTHOPEDIC SURGERY	1662
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	090	0.0198	10.78	60	384	2007-04	ORTHOPEDIC SURGERY	1248
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	090	0.0943	11.00	60	243	2009-04	NEUROSURGERY	2414
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	0.0484	11.10	60	328	2007-02	ORTHOPEDIC SURGERY	174
41120	Glossectomy; less than one-half tongue	090	0.0715	11.14	60	278	2005-08	OTOLARYNGOLOGY	2232
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	0.0942	11.15	60	239	2010-10	OBSTETRICS/GYNECOLOGY	1737
65850	Trabeculotomy ab externo	090	0.1109	11.39	60	233	2005-08	OPHTHALMOLOGY	620
54437	Repair of traumatic corporeal tear(s)	090	0.0872	11.50	60	264	2015-01	UROLOGY	54
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	090	0.0923	11.60	60	267	2007-04	OBSTETRICS/GYNECOLOGY	986

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare volume cited below

Specialty Otolaryngology Frequency 27 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Industry data indicates that approximately .5-1% of cases of 69716 will be revised, we estimate 900 cases per year of 69716, and 9 is 1% of that volume.

Specialty Otolaryngology Frequency 9 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69726 Tracking Number Original Specialty Recommended RVU: **10.00**
Presented Recommended RVU: **5.93**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **5.93**

CPT Descriptor: Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with a right mixed hearing loss had previous placement of a percutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed without replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 33% , In the ASC 36%, In the office 30%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed removal site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked in the region of the previous incision. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium fixture in the patient's skull is drilled around the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound where the external abutment of the implant is debrided then closed followed by closure of the linear incision anterior to the implant site in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other

complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69726					
Sample Size:	533	**Resp N:**	66			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	5.00	10.00	**10.90**	12.00	20.45	
Pre-Service Evaluation Time:			**32.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	5.00	20.00	**30.00**	45.00	187.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69726	**Recommended Physician Work RVU: 5.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**32.00**	**33.00**	**-1.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	19.00	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	39.00	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66185	090	10.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
27829	090	8.80	**RUC Time**

CPT Descriptor Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 43.9 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 69726	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **66185**
Median Pre-Service Time	45.00	72.00	25.00
Median Intra-Service Time	30.00	75.00	65.00
Median Immediate Post-service Time	15.00	30.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	39.0	62.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**148.00**	**258.00**	**259.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	7%	31%	48%	14%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	31%	41%	28%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	45%	31%	24%
Physical effort required	34%	38%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	44%	48%	6%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	63%	38%	0%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	63%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	63%	38%	0%
Physical effort required	50%	50%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	38%	62%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

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Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **5.93 and 30 minutes of intra service time**, based on a crosswalk to CPT 53852. This is below our survey's 25th percentile RVW and utilizes our survey's median intra-service time.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 32 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. One level three office visit, 99213; and one level two office visit, 99212. Our expert panel agreed.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	090	0.0888	7.91	45	179	2000	General Surgery	106
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	090	0.0892	7.97	45	185	2005	Ophthalmology	54853
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare data below.

Specialty Otolaryngology Frequency 3 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 1% of future 69714 volume will have to be removed. The 2019 volume of 69714 was 993 cases, which we anticipate will drop approximately 94% to 93 cases going forward. One percent of 93 is .93, or one case per year.

Specialty Otolaryngology Frequency 1 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69727 Tracking Number Original Specialty Recommended RVU: **10.98**
Presented Recommended RVU: **7.13**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **7.13**

CPT Descriptor: Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male with right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well, but has now become infected. The device is removed without replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 46% , In the ASC 51%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed removal site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium transducer and the respective fixture screws in the patient's skull is drilled out to free the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69727					
Sample Size:	533	**Resp N:**	59			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**0.00**	1.00	10.00	
Survey RVW:	5.00	10.98	**12.00**	12.75	28.00	
Pre-Service Evaluation Time:			**36.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	12.00	30.00	**45.00**	60.00	164.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69727	**Recommended Physician Work RVU: 7.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
41120	090	11.14	**RUC Time**

CPT Descriptor Glossectomy; less than one-half tongue

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
28003	090	9.06	**RUC Time**	5,470

CPT Descriptor 2 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

Other Reference CPT Code	Global	Work RVU	Time Source
51647	090	11.30	**RUC Time**

CPT Descriptor Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 22.0 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 13.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 69727	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **41120**
Median Pre-Service Time	46.00	72.00	60.00
Median Intra-Service Time	45.00	75.00	60.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	39.0	62.00	109.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**164.00**	**258.00**	**278.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	38%	23%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	46%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	46%	15%	38%
Physical effort required	38%	38%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	31%	46%	23%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	50%	13%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	38%	50%	12%
Physical effort required	38%	50%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	63%	38%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **7.13 and 45 minutes of intra service time**, based on a crosswalk to CPT 37718. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. One level three office visit, 99213 and one level two office visit, 99212.Our expert panel agreed.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	090	0.0888	7.91	45	179	2000	General Surgery	106
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	090	0.0892	7.97	45	185	2005	Ophthalmology	54853
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare volume cited below.

Specialty Otolaryngology Frequency 27 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Industry data estimates .5-1% of 69716 cases will have to be removed. We estimated 900 cases per year of 69716, and 1% of that is 9.

Specialty Otolaryngology Frequency 9 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

SS Rec Summary

ISSUE: Transcutaneous Passive Implant Temporal Bone (BAHA)

TAB: 18

Source	CPT	Global	DESC	Resp	WPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	Office 38	39	15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and	14	0.068	0.039			10.15			258	40	12	20			75			30						0.5			2	1						
2nd REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	14	0.028	0.033			12.00			367	40	10	10			45			20			1	1	2	1.0			3							
CURRENT	69714	90	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		0.098	0.051			14.45			284	55					90			30						1.0			1	3						
SVY	69714		Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	73	0.188	0.063	1.00	11.00	12.00	14.00	17.40	190	34	10	10	10	25	40	46	155	15						0.5			2	1			0	3	8	12	45
W/ EXP				69	0.194	0.063	1.00	11.00	12.00	14.00	17.40	189	35	10	10	10	25	40	45	155	32									2	1			1	5	8	13	45
W/OUT EXP				4	0.188	0.067	1.00	10.39	10.88	11.74	13.20	162	29	9	20	20	24	42	67	90	23									1	1						
CROSSWALK	52400	90	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral		0.126	0.044			8.69			198	72.5	10	15			40			25						0.5			1							
REC	69714	90	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.110	0.048			8.69			182	33	3	10			40			15						0.5			2	1						
1st REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	12	0.028	0.033			12.00			367	40	10	10			45			20			1	1	2	1.0			3							
2nd REF	15730	90	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	6	0.100	0.053			13.50			256	40	3	15			90			17.5						0.5			1	3						
CURRENT	NEW	90			#DIV/0!	#DIV/0!																														
SVY	69716		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to	67	0.151	0.068	1.00	12.00	13.00	15.39	25.00	192	32	10	10	10	40	60	70	159	15						0.5			2				0	2	4	10	30
W/ EXP				58	0.183	0.070	1.00	12.00	13.13	15.68	25.00	187	35	10	10	10	40	48	60	159	15									3				1	3	5	10	30
W/OUT EXP				9	0.141	0.064	10.50	11.25	12.00	12.50	17.40	187	40	15	10	20	45	65	90	150	25										2						
CROSSWALK	50590	90	Lithotripsy, extracorporeal shock wave		0.091	0.047			9.77			207	33	3	15			60			15						0.5			2	1						
REC	69716	90	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.100	0.053			9.77			185	32	3	10			60			15						0.5			2							
1st REF	15260	90	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids,	9	0.056	0.043			11.64			273	17	1	10			100			30									5							
2nd REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	9	0.068	0.039			10.15			258	40	12	20			75			30						0.5			2	1						
CURRENT	69717	90	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator;		0.105	0.055			15.43			282	50					95			28						1.0			1	3						
SVY	69717		Revision/replacement (including removal of existing device), osseointegrated implant,	64	0.166	0.061	10.00	11.48	12.50	14.00	25.00	205	37	10	10	10	30	45	60	201	15						0.5			3				0	0	1	2	10
W/ EXP				40	0.200	0.071	10.00	11.69	13.00	16.25	25.00	183	40	11	10	10	30	45	60	201	15									2	1			1	1	2	3	10
W/OUT EXP				24	0.225	0.077	10.00	11.12	12.00	13.62	17.30	155	37	10	11	15	30	40	60	120	18									1	1						
CROSSWALK	27829	90	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed		0.046	0.032			8.80			271	45	10	15			45			20					1	1.0			2	2						
REC	69717	90	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.100	0.047			8.80			187	33	3	10			45			15						0.5			2	1						
1st REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	8	0.028	0.033			12.00			367	40	10	10			45			20			1	1	2	1.0			3							
2nd REF	15730	90	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	7	0.100	0.053			13.50			256	40	3	15			90			17.5						0.5			1	3						
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69719		Revision/replacement (including removal of existing device), osseointegrated implant,	59	0.149	0.066	10.14	12.00	13.00	15.48	27.00	197	37	10	10	14	43	60	80	201	15						0.5			2				0	0	1	2	10
W/ EXP				31	0.167	0.073	10.15	12.04	13.60	16.67	27.00	186	35	15	10	24	45	60	90	201	20									2				1	1	2	3	10
W/OUT EXP					0.164	0.073	10.50	12.00	12.85	14.56	20.00	175	40	10	11	14	30	60	75	120	15									1	1						
CROSSWALK	50590	90	Lithotripsy, extracorporeal shock wave		0.091	0.047			9.77			207	33	3	15			60			15						0.5			2	1						
REC	69719	90	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.099	0.053			9.77			186	33	3	10			60			15						0.5			2							
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	29	0.068	0.039			10.15			258	40	12	20			75			30						0.5			2	1						
2nd REF	66185	90	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	8	0.060	0.041			10.58			259	19	1	5			65			10						0.5			4	3						
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69726		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	66	0.248	0.070	5.00	10.00	10.90	12.00	20.45	155	32	10	10	5	20	30	45	187	15						0.5			1	1			0	0	1	2	10
W/ EXP				48	0.277	0.081	5.00	10.00	10.69	12.24	20.45	132	35	10	10	5	20	30	45	128	15									2				1	1	2	3	10
W/OUT EXP				18	0.265	0.074	8.00	10.04	11.07	11.89	14.50	150	35	15	11	5	21	30	45	187	20									1	1						
CROSSWALK	53852	90	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy		0.071	0.042			5.93			142	17	6	5			30			15									3							
REC	69726	90	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.088	0.040			5.93			148	32	3	10			30			15						0.5			1	1						
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	13	0.068	0.039			10.15			258	40	12	20			75			30						0.5			2	1						
2nd REF	41120	90	Glossectomy; less than one-half tongue	8	0.071	0.040			11.14			278	30	15	15			60			30						0.5		1	3						
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69727		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to	59	0.188	0.069	5.00	10.98	12.00	12.75	28.00	174	36	10	10	12	30	45	60	164	15						0.5			1	1			0	0	0	1	10
W/ EXP				27	0.179	0.066	10.00	11.27	12.00	14.00	28.00	182	35	10	10	12	30	45	60	164	20									2	1			1	1	1	2	10
W/OUT EXP				32	0.271	0.091	5.00	10.75	11.50	12.13	25.00	127	40	10	11	14	23	35	53	120	15									1							
CROSSWALK	37718	90	Ligation, division, and stripping, short saphenous vein		0.078	0.040			7.13			178	35	10	10			45			20						0.5			1	1						
REC	69727	90	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.085	0.043			7.13			164	33	3	10			45			15						0.5			1	1						

FACILITY DIRECT PE INPUTS **CPT CODE(S):_69714, 69717, 69716-27_____**

SPECIALTY SOCIETY(IES):_AAO-HNS_____

PRESENTER(S):_R. Peter Manes, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
69714	Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69717	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69719	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69726	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69727	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
69714	A 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. He is unable to wear traditional hearing aids. Implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.
CPT Code	**Vignette**
69716	A 48-year-old male with a left mixed hearing loss seeks intervention for improved quality of life at work and socially. Placement of a magnetic transcutaneous bone anchored hearing device is performed.
CPT Code	**Vignette**

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

69717	A 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. The device is removed and a new device is placed at a different site.
CPT Code	**Vignette**
69719	A 59-year-old female with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed and a new device is placed at a different site.
CPT Code	**Vignette**
69726	A 59-year-old female with a right mixed hearing loss had previous placement of a percutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed without replacement.
CPT Code	**Vignette**
69727	A 62-year-old male with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well, but has now become infected. The device is removed without replacement.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, sleep medicine, and otology. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing codes 69714 and 69717 were utilized as comparison codes for all new codes in the family.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence*

guidelines) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

During the pre-service clinical staff are completing pre-service diagnostic and referral forms, coordinating pre-surgery services including test results, scheduling space and equipment in the facility, providing pre-service education and obtaining consent from the patient, and completing pre-procedure phone calls and prescriptions.

   b. Service period (includes pre, intra and post):

During the service period the clinical staff assist with a half discharge management visit for the patient. This includes post-procedure care instructions. They also clean the instruments used during each post operative visit.

   c. Post-service period:

During post operative visits the patient is checked in via front-desk staff. Clinical staff collects vitals from the patient. An exam chair/table and light are required with paper covering for the exam furniture. A postoperative wound kit for removal of sutures/staples is required. The clinical staff assists the physician with removal of the sutures.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning, surgical instruments	**SA043**	**pack**	1	**10.7922**
gloves, non-sterile		pair	2	
gown, staff, impervious		item	1	
face shield, splash protection		item	1	
autoclave bag		item	1	
autoclave tape		yd	0.33	
enzymatic detergent		oz	1	
cleaning brush, instruments		item	1	

DESCRIPTION	Code	Unit
pack, post-op incision care (suture)	**SA054**	**pack**
kit, suture removal		kit
povidone soln (Betadine)		ml
gauze, sterile 4in x 4in		item
gloves, sterile		pair
steri-strip (6 strip uou)		item
swab-pad, alcohol		item
tape, surgical paper 1in (Micropore)		inch
tincture of benzoin, swab		item

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ234 suction and pressure cabinet, ENT (SMR)
EQ183 microscope, operating
EQ170 light, fiberoptic headlight w-source
EF008 chair with headrest, exam, reclining

The office visit formula was used for all these pieces of equipment.

EQ137 basic instrument pack

The instrument pack formula was used for this item.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is

reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Clinical staff time in the preservice period remains unchanged for all codes in the family. All codes have cleaning time added in the intra service time period to allocate time to cleaning the instruments used at each post op visit. Post-operative time has changed, commensurate with the survey data and recommended post op visits. Two codes (64714/64717) have 3 post op visits and the rest of the family has 2 post op visits.

Some supplies were reduced commensurate with reducing the post-operative visits per our survey data. Additionally, we added a minimum multi-specialty pack for each post op visit and reduced individual, unnecessary line items. We also added a basic instrument pack and cleaning pack for the instruments which will be used at each post op visit. The items include a tuning fork, Frasier tip suctions, and ear curettes. We removed the suture/staple pack and replaced it with just a suture pack.

Equipment times were reduced based on less office visits and lower overall office visit post time. The instrument pack formula was used for the new instrument pack and cleaning time was accounted for.

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFERENCE**	
2						**CPT Code 69714**		**CPT Code 69714**		**CPT Code 69714**	
3		***RUC Collaboration Website***				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D				5		5		5
16	CA002		L037D				20		20		20
17	CA003		L037D				8		8		8
18	CA004		L037D				20		20		20
19	CA005		L037D				7		7		7
20	CA006		L037D								
21	CA007		L037D								
22	CA008		L037D								
23			L037D								
26		*Other activity: please include short clinical description here and type*	L037D								
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009		L037D								
34	CA010		L037D								
35	CA011		L037D								
36	CA012		L037D								
37	CA013		L037D								
38	CA014		L037D								
39	CA015		L037D								
40	CA016		L037D								
41	CA017		L037D								
42			L037D								
45		*Other activity: please include short clinical description here and type*	L037D								
48		**Intra-service (of service period)**									
49	CA018		L037D								
50	CA019		L037D								
51	CA020		L037D								
52	CA021		L037D								
55			L037D								
56		*Other activity: please include short clinical description here and type*	L037D								
59		**Post-Service (of service period)**									
60	CA022		L037D								
61	CA023		L037D								
62	CA024		L037D								
63	CA025		L037D								
64	CA026		L037D						30		
65	CA027		L037D								
66	CA028		L037D								
67	CA029		L037D								
68	CA030		L037D								
69	CA031		L037D								
70	CA032		L037D								
71	CA033		L037D								
72	CA034		L037D								
73	CA035		L037D								
74	CA036		L037D			**n/a**	**6**	**n/a**	**6**	**n/a**	**6**
75			L037D								
78		*Other activity: please include short clinical description here and type*	L037D								
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037		L037D								
85	CA038		L037D								
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27				3				3
89		99213 36 minutes	36				1		3		1
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039		L037D			**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
93			L037D								
96		*Other activity: please include short clinical description here and type*	L037D								
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFERENCE**	
2						**CPT Code 69714**		**CPT Code 69714**		**CPT Code 69714**	
3		***RUC Collaboration Website***				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**
102	SA043								3		
103	SA048								3		
104	SA053						1		**0**		1
105	SA054								**1**		
106	SB012						4				4
107	SB024						1				1
108	SB026						4				4
109	SB027						8				8
110	SB034		3.4				8				8
111	SB044						4				4
112	SD009						4		1		4
113	SD132						8		2		8
114	SG006						1				1
115	SG016						1				1
116	SG020						1				1
117	SG031						4				4
118	SG042						1				1
119	SG055						14		2		14
120	SG079						48				48
121	SG081						16		1		16
122	SG082						4				4
123	SH024						4				4
124	SJ007						20		1		20
125	SJ010						4				4
126	SJ028						40				40
127	SJ046						20				20
128	SJ060						1				1
129	SM001						4				4
130											
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
133	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
135	EQ234			Office Visits			117		108.0		117
136	EQ183			Office Visits			117		108.0		117
137	EQ170			Office Visits			117		108.0		117
138	EF008			Office Visits			117		108.0		117
139	EQ137			Instrument Packs					30.0		
146											
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	M	N	O	P	Q	R	S	T	U
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**REFERENCE**		**RECOM**
2			**CPT Code 69716**		**CPT Code 69717**		**CPT Code 69717**		**CPT Code 69717**		**CPT Co**
3		***RUC Collaboration Website***	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Revision/r (including existing osseointegr skull; with transcu attachmer
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ 13.60**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001			5		5		5		5	
16	CA002			20		20		20		20	
17	CA003			8		8		8		8	
18	CA004			20		20		20		20	
19	CA005			7		7		7		7	
20	CA006										
21	CA007										
22	CA008										
23											
26		*Other activity: please include short clinical description here and type*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009										
34	CA010										
35	CA011										
36	CA012										
37	CA013										
38	CA014										
39	CA015										
40	CA016										
41	CA017										
42											
45		*Other activity: please include short clinical description here and type*									
48		**Intra-service (of service period)**									
49	CA018										
50	CA019										
51	CA020										
52	CA021										
55											
56		*Other activity: please include short clinical description here and type*									
59		**Post-Service (of service period)**									
60	CA022										
61	CA023										
62	CA024										
63	CA025										
64	CA026			20				30			
65	CA027										
66	CA028										
67	CA029										
68	CA030										
69	CA031										
70	CA032										
71	CA033										
72	CA034										
73	CA035										
74	CA036		**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**
75											
78		*Other activity: please include short clinical description here and type*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037										
85	CA038										
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes				3				3	
89		99213 36 minutes		2		1		3		1	
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039		**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**	**0.0**
93											
96		*Other activity: please include short clinical description here and type*									
99		**End: with last office visit before end of global period**									

	A	B	M	N	O	P	Q	R	S	T	U
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**REFERENCE**		**RECOM**
2			**CPT Code 69716**		**CPT Code 69717**		**CPT Code 69717**		**CPT Code 69717**		**CPT Co**
3		***RUC Collaboration Website***	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Revision/r (including existing osseointegr skull; with transcu attachmer
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ 13.60**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ 13.60**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**
102	SA043			2				3			
103	SA048			2				3			
104	SA053			**0**		1		**0**		1	
105	SA054			**1**				**1**			
106	SB012					4				4	
107	SB024					1				1	
108	SB026					4				4	
109	SB027					8				8	
110	SB034					4				8	
111	SB044					4				4	
112	SD009			1		4		1		4	
113	SD132			2		8		2		8	
114	SG006					1				1	
115	SG016					1				1	
116	SG020					1				1	
117	SG031					4				4	
118	SG042					1				1	
119	SG055			2		14		2		14	
120	SG079					48				48	
121	SG081			1		16		1		16	
122	SG082					4				4	
123	SH024					4				4	
124	SJ007			1		4		1		20	
125	SJ010					20				4	
126	SJ028					4				40	
127	SJ046					40				20	
128	SJ060					20				1	
129	SM001					1				4	
130						4					
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
133	**Equipment Code**	**EQUIPMENT**									
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
135	EQ234			72.0		117		108.0		117	
136	EQ183			72.0		117		108.0		117	
137	EQ170			72.0		117		108.0		117	
138	EF008			72.0		117		108.0		117	
139	EQ137			20.0				30.0			
146											
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	V	W	X	Y	Z	AA	AB	AC	AD
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**REFERENCE**		**RECOMMENDED**		**REFERENCE**		**RECOMMENDED**	
2			**de 69719**	**CPT Code 69717**		**CPT Code 69726**		**CPT Code 69717**		**CPT Code 69727**	
3		***RUC Collaboration Website***	eplacement removal of device), ated implant, n magnetic taneous t to external	Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**158.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		5		5		5		5		5
16	CA002		20		20		20		20		20
17	CA003		8		8		8		8		8
18	CA004		20		20		20		20		20
19	CA005		7		7		7		7		7
20	CA006										
21	CA007										
22	CA008										
23											
26		*Other activity: please include short clinical description here and type*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009										
34	CA010										
35	CA011										
36	CA012										
37	CA013										
38	CA014										
39	CA015										
40	CA016										
41	CA017										
42											
45		*Other activity: please include short clinical description here and type*									
48		**Intra-service (of service period)**									
49	CA018										
50	CA019										
51	CA020										
52	CA021										
55											
56		*Other activity: please include short clinical description here and type*									
59		**Post-Service (of service period)**									
60	CA022										
61	CA023										
62	CA024										
63	CA025										
64	CA026		20				20				20
65	CA027										
66	CA028										
67	CA029										
68	CA030										
69	CA031										
70	CA032										
71	CA033										
72	CA034										
73	CA035										
74	CA036		**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**
75											
78		*Other activity: please include short clinical description here and type*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037										
85	CA038										
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes			3		1		3		1
89		99213 36 minutes	2		1		1		1		1
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039		**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**
93											
96		*Other activity: please include short clinical description here and type*									
99		**End: with last office visit before end of global period**									

	A	B	V	W	X	Y	Z	AA	AB	AC	AD
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**REFERENCE**		**RECOMMENDED**		**REFERENCE**		**RECOMMENDED**	
2			**de 69719**	**CPT Code 69717**		**CPT Code 69726**		**CPT Code 69717**		**CPT Code 69727**	
3		***RUC Collaboration Website***	eplacement removal of device), ated implant, n magnetic taneous t to external	Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**158.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**	**149.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**	**63.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**	**$ -**	**$ 27.20**	**$ -**	**$ -**
102	SA043		2				2				2
103	SA048		2				2				2
104	SA053		**0**		1		**0**		1		**0**
105	SA054		**1**				**1**				**1**
106	SB012				4				4		
107	SB024				1				1		
108	SB026				4				4		
109	SB027				8				8		
110	SB034				8				8		
111	SB044				4				4		
112	SD009		1		4		1		4		1
113	SD132		2		8		2		8		2
114	SG006				1				1		
115	SG016				1				1		
116	SG020				1				1		
117	SG031				4				4		
118	SG042				1				1		
119	SG055		2		14		2		14		2
120	SG079				48				48		
121	SG081		1		16		1		16		1
122	SG082				4				4		
123	SH024				4				4		
124	SJ007		1		20		1		20		1
125	SJ010				4				4		
126	SJ028				40				40		
127	SJ046				20				20		
128	SJ060				1				1		
129	SM001				4				4		
130											
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
133	**Equipment Code**	**EQUIPMENT**									
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
135	EQ234		72.0		117		63.0		117		63.0
136	EQ183		72.0		117		63.0		117		63.0
137	EQ170		72.0		117		63.0		117		63.0
138	EF008		72.0		117		63.0		117		63.0
139	EQ137		20.0				20.0				20.0
146											
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Screen: High Volume Growth

April 2021

Cardiac Ablation – Tab 7

The RUC identified CPT code 93656 with Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019e. In January 2020, the RUC recommended to refer this issue to the CPT Editorial Panel in May 2020 for revision and bundling. Technology and clinical practice have changed since these codes were developed in 2011. Based on the billed together data for these and related codes, the specialty societies recommended referral to CPT to update code descriptors and likely bundle services now commonly performed together, such as 3D mapping. In October 2020, the CPT Editorial Panel revised one code (93653) to bundle with 3D mapping and to include "induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus," and another (93656) to add 3D mapping and "left atrial pacing and recording from coronary sinus or left atrium" and "intracardiac echocardiography including imaging supervision and interpretation" to their descriptors.

The surveying specialties had submitted a letter to the CPT Editorial Panel in December 2020 requesting that the coding changes for these services to be rescinded for CPT 2022 due to the specialty's concern that the RUC survey respondents may have been confused about the coding changes. In February 2021, the CPT Editorial Panel Executive Committee did not rescind their changes, which were among the coding changes for CPT 2022. Since the request to rescind the changes was not considered by CPT until after the January 2021 RUC meeting and January 2021 was the last RUC meeting of the CPT 2022 cycle, the RUC had recommended for these services to be valued as interim for CPT 2022 and that the codes would be resurveyed and reviewed at the April 2021 RUC meeting.

93653 ***Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry***
The RUC reviewed the survey results from 62 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 15.00 for CPT code 93653. The RUC recommends 31 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time and 30 minutes of immediate post-service time. The RUC noted that CPT code 93653 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 93621 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)*, which previously were separately reported add-on services.

The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much greater feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was

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contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. For instance, the ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more data points to create the 3-dimensional map, the physician still needs to make sure every one of those points are accurate as review of points is not automated.

The specialties noted that 93653 is typically the most intense service to perform among the three base codes in this family (93653, 93654 and 93656). CPT code 93653 is typically performed on a young patient who does not have other conditions and the ablation site occurs very close to the patient's innate conduction system. There is an approximately 0.5 percent to 1 percent risk of causing heart block requiring a permanent pacemaker. The time when the physician is applying radiofrequency energy is extraordinarily intense as opposed to the other two ablation services, 93654 and 93656, which are longer procedures on generally sicker patients and the intensity is more spread out over time.

To justify a value of 15.00, the RUC compared the survey code to top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that both services involve an identical amount of intra-service time and that 80 percent of the survey respondents who selected the top key reference code also indicated that the survey code is a more intense and complex procedure to perform. However, the reference code involves more total time. The RUC also compared the survey code to 2nd key reference code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, intra-service time of 90 minutes, total time of 183 minutes) and noted that the survey code involves much more intra-service time and somewhat more total time. 75 percent of the survey respondents who selected this reference code indicated the survey code was more intense and complex, however, the RUC recommendation of 15.00 has a lower intensity than the reference code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93653 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 15.00 for CPT code 93653.**

93654 ***Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed***

The RUC reviewed the survey results from 63 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 18.10 for CPT code 93654. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 200 minutes of intra-service time and 33 minutes of immediate post-service time. The RUC noted that, unlike codes 93653 and 93655, the work of intracardiac electrophysiologic 3D mapping was already bundled into this service prior to the CPT revisions.

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The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

In addition, the specialties noted that ventricular tachycardia patients are the most complicated, often with recurrent heart failure admissions and these patients typically have with an implantable defibrillator. The defibrillator must be turned off prior to the procedure and the patient requires more pre-service evaluation time to make sure that they are hemodynamically stable prior to and throughout the procedure.

To justify a work value of 18.10, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 20 more minutes of intra-service time and 21 more minutes of total time. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200 minutes, total time of 355 minutes) and noted that although both services involve an identical amount of intra-service time, it would be appropriate to value the survey code somewhat lower due to the disparity in total time. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93654 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 18.10 for CPT code 93654.**

93655 ***Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 63 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 7.00 for CPT code 93655. The RUC recommends 60 minutes of intra-service time for this add-on service.

To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93655 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 7.00 for CPT code 93655.**

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93656 ***Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed***
The RUC reviewed the survey results from 61 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 17.00 for CPT code 93656. The RUC recommends 35 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time and 30 minutes of immediate post-service time. The RUC noted that CPT code 93656 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 93662 *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)*, which previously were separately reported add-on services.

The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

To justify a value of 17.00, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that both services involve an identical amount of intra-service time, whereas the reference code involves slightly more total time and is also slightly more intense to perform. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200, total time of 355) and noted that the reference code involves 20 more minutes of intra-service time and 92 more minutes of total time, justifying a lower valuation for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to this survey code. The RUC concluded that CPT code 93656 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 17.00 for CPT code 93656.**

93657 ***Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 61 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 7.00 for CPT code 93657. The RUC recommends 60 minutes of intra-service time for this add-on service.

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To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93657 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 7.00 for CPT code 93657.**

Affirmation of RUC Recommendations

The RUC reviewed the specialty societies' request to affirm the recent RUC valuations for CPT codes 93613, 93621 and 93662. The RUC noted that for 93613, this is also the code's current 2021 CMS value. For code 93621, this service was surveyed for the October 2020 RUC meeting for CY 2022 and represents a reduction compared to the current 2021 CMS value.

For code 93662, the RUC recommendation would represent an increase compared to the current 2021 CMS value. In the CY 2021 Medicare Physician Payment Schedule Final Rule, CMS' rationale for not accepting the RUC recommendation and instead implementing a lower value for 93662 was the 45 percent decrease in total time from when the service was previously surveyed in 2000. The Agency's 1.44 work value was derived from using a work value crosswalk to code 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure).* Unfortunately, the coronary IVUS crosswalk code (92979) that CMS had used to determine an alternate valuation was flawed because the nature of the services performed, intensity and work involved are different, with intracardiac echocardiography (ICE) and intravascular ultrasound (IVUS) performed in different parts of the heart for different reasons. Coronary IVUS is performed inside the coronary arteries to guide diagnostic catheterization and/or percutaneous coronary interventions. ICE is used to provide high-resolution real-time visualization of cardiac structures, continuous monitoring of a catheter location within the heart. It commonly guides trans-septal puncture where the operator creates a hole in the septum of the heart to gain access to the other cardiac chambers on the other side of the heart and is useful for early recognition of procedural complications, such as pericardial effusion or thrombus formation. ICE remains highly technical in nature and requires the patient to be anesthetized, which is not required in IVUS use. ICE is most used with atrial fibrillation ablations, a highly technical and challenging service, this reinforces the intensity of ICE.

The RUC recommendation for CPT code 93662 was based on the survey 25th percentile work RVU from robust survey results of 42 cardiologists as well as a favorable comparison to code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and intra-service time of 20 minutes) and MPC code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and intra-service time of 30 minutes). Both reference services bracket code 93662 in both physician work and time.

The RUC recommends affirming the recent RUC-recommended work RVU of 5.23 for CPT code 93613, 1.75 for CPT code 93621 and 2.53 for CPT code 93662.

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Practice Expense
No direct practice expense inputs are recommended for CPT codes 93653-93657 as they are facility-only services.

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Cardiovasular** **Intracardiac Electrophysiological Procedures/Studies**				
✚93613	Y1	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) (Use 93613 in conjunction with 93620~~, 93653, 93656~~) *(Do not report 93613 in conjunction with 93609, 93654)*	ZZZ	5.23 (No Change) (Affirmed February 2017 RUC recommendation)
✚93621	Y2	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure) (Use 93621 in conjunction with 93620~~, 93653, 93654~~) (Do not report 93621 in conjunction with 93656)	ZZZ	1.75 (Affirmed October 2020 RUC recommendation)

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▲93653	Y3	Comprehensive electrophysiologic evaluation ~~including~~ with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including ~~with~~ intracardiac electrophysiologic 3-dimensional mapping, ~~induction or attempted induction of an arrhythmia with right atrial pacing and recording,~~ right ventricular pacing and recording, ~~(when necessary),~~ left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed ~~(when necessary),with intracardiac catheter ablation of arrhythmogenic focus~~; ~~with~~ treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry (Do not report 93653 in conjunction with 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, ~~93642~~, 93654, 93656)	000	15.00
▲93654	Y4	with treatment of ventricular tachycardia or focus of ventricular ectopy including ~~intracardiac electrophysiologic 3D mapping, when performed, and~~ left ventricular pacing and recording, when performed (Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, ~~93642~~, 93653, 93656)	000	18.10
(f)93655	Y5	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure) (Use 93655 in conjunction with 93653, 93654, 93656)	ZZZ	7.00

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▲93656	Y6	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, ~~when necessary,~~ right ventricular pacing/recording, ~~when necessary~~, and His bundle recording, when performed ~~necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation~~ (Do not report 93656 in conjunction with 93279, 93280, 93281, 93282, 93283, 93284, 93286, 93287, 93288, 93289, 93462, 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93653, 93654, 93662)	000	17.00
(f)93657	Y7	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure) (Use 93657 in conjunction with 93656)	ZZZ	7.00
✚93662	Y8	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	ZZZ	2.53 (Affirmed May 2019 RUC recommendation)

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	Elements of Cardiac Ablation Codes								
	93653 SVT Ablation			93654 VT Ablation			93656 AF Ablation		
Procedure/Services included with Ablations	Inherent	Bundled	Not Bundled, Sometimes Performed	Inherent	Bundled	Not Bundled, Sometimes Performed	Inherent	Bundled	Not Bundled, Sometimes Performed
Insert/reposition multiple catheters	X			X			X		
Transseptal catheterization(s) (93462)							X		
Induction or attempted induction of arrhythmia with Right Atrial pacing and recording	X			X				X	
Intracardiac ablation of arrhythmia	X			X			X		
SVT Ablation	X								
VT Ablation				X					
AF ablation							X		
Intracardiac 3d mapping (93613)		X			X			X	
Right Ventricular pacing and recording		X			X			X	
Left Atrial pacing and recording from coronary sinus or Left Atrium (93612)		X			X			X	
His Bundle recording		X			X			X	
Left Ventricular pacing and recording					X				
Intracardiac Echocardiography (93662)			X			X		X	

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93653 Tracking Number Y1 Original Specialty Recommended RVU: **15.00**
Presented Recommended RVU: **15.00**
Global Period: 000 Current Work RVU: **14.75** RUC Recommended RVU: **15.00**

CPT Descriptor: Comprehensive electrophysiologic evaluation including with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
(Do not report 93653 in conjunction with 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93642, 93654, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female has recurrent palpitations. an event monitor has documented supraventricular tachycardia (svt). a comprehensive electrophysiologic evaluation with catheter ablation is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and supraventricular tachycardia ablation are explained to the patient. Management of antiarrhythmic medications is communicated to the patient. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. Informed consent is obtained. The patient is evaluated on the day of the procedure with a history and physical examination. Preprocedure laboratory testing is reviewed as well as current medications and changes in health status.

Description of Intra-Service Work: Local analgesia is administered along with anesthesia appropriate to the patient including moderate sedation. Venous access is obtained. Arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle may be obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. Pacing and sensing is performed in the right atrium, left atrium, and right ventricle. His bundle recording is obtained. Refractory periods are measured. Attempts at arrhythmia induction are performed via maneuvers that include burst pacing and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple atrial and ventricular sites.

Once the SVT is induced, pacing maneuvers are performed to elucidate the mechanism of the tachycardia. A combination of diagnostic maneuvers is performed and a high definition anatomical map of the chamber(s) of interest is generated. Voltage and electrical activation in the arrhythmia and/or in sinus rhythm is performed to identify normal activation, location of scar, and mechanism of the arrhythmia. 3-dimensional mapping activation and voltage mapping may be performed to assist in identifying the arrhythmia mechanism, substrate, cardiac anatomy, and to guide catheter ablation. Catheter ablation may then be performed. An ablation catheter is maneuvered from the sites of vascular access to the appropriate cardiac location to facilitate delivery of ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer mapping system to assist in identifying the arrhythmia circuit, localizing the origin (for focal arrhythmias) or the critical isthmus (reentrant arrhythmias). The 3D mapping system is calibrated, and recordings are made during sinus rhythm (to identify normal activation and location of scar) and during each distinct arrhythmia. The physician then analyzes the computer-generated map, ensuring that electrograms are annotated correctly and that the display parameters are correct for the specific arrhythmia being mapped. Based upon the data from the 3D mapping system, endocardial electrograms, surface ECG and the response of the SVT to pacing maneuvers, the ablation catheter is advanced to the point of earliest activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Radiofrequency (or cryo) ablation is then performed. If initial mapping in one chamber does not lead to complete identification of the essential arrhythmia circuit (either based on analysis of the map or based on incomplete ablation result, then the mapping catheter(s) is/are moved into another cardiac chamber and an additional 3D map is generated to aid in diagnosis; this is repeated until the arrhythmia mechanism is fully characterized and ablation is deemed completely successful. A final report that includes the mapping procedure and findings is prepared.

To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures. Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed. Sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family, and postprocedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93653					
Sample Size:	1036	**Resp N:**	62			
Description of Sample:	randomly selected electrophysiologists from the two societies					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**40.00**	50.00	200.00
Survey RVW:	7.25	15.00	**18.00**	23.25	37.00
Pre-Service Evaluation Time:			**31.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	3.00	120.00	**120.00**	150.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93653	**Recommended Physician Work RVU: 15.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**31.00**	**40.00**	**-9.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33340	000	14.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 **% of respondents:** 32.2 **%**

Number of respondents who choose 2nd Key Reference Code: 16 **% of respondents:** 25.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93653	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: 33340
Median Pre-Service Time	58.00	30.00	40.00
Median Intra-Service Time	125.00	120.00	90.00
Median Immediate Post-service Time	30.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**213.00**	**210.00**	**160.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	45%	35%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	10%	85%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	35%	65%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	19%	50%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	47%	53%
Physical effort required	13%	34%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	62%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the codes are

re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: **93653**, 93654, 93655, 93656, 93657. As indicated in the summary spreadsheet, revised 93653 is now a more comprehensive, bundled service that includes the work of 3D mapping (93613) and left atrial pacing/recording (93621). The societies surveyed members late 2020 and presented data in January 2021. Due to inconsistencies in the survey data and in order to better convey the bundled services to respondents, the ACC and HRS resurveyed members March 2021.

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. To remedy the above-described shortcomings, the societies work with the Research Subcommittee to deploy several tactics to obtain more consistent survey results. First, fake/dummy codes were used in the survey so that respondents would not presume to know the code descriptors. Second, additional language noting the bundling was included in the survey invitation. Third, respondents were required to attest they had read and understood the new language before completing the survey.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 32% of respondents. 80% of the respondents indicated that 93653 was more complex. The second reference code was 33340 for percutaneous transcatheter closure of left atrial appendage with endocardial implant. It was selected by over 25% of respondents. About 75% of the respondents indicated that 93653 was more intense/complex overall.

Rationale

In reviewing the survey data to develop work recommendations, the expert panel believes the data accurate reflects the newly bundled services, 93653 and 93656. The societies believe the technological advances made in patient care indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion have clearly altered the way this service is provided. Over time, the mapping systems have improved, now providing much more detailed and accurate anatomical and electrical activation mapping, often removing the need for fluoroscopy completely. Catheter technology has advanced, providing real-time assessment of the quality of contact between the catheter tip and the endocardial tissue. Last, the 3D mapping systems in conjunction with new catheter technology are now able to provide real-time assessment of the quality of radiofrequency ablation lesion formation. This feature has allowed operators to significantly shorten the duration of each radiofrequency application while also improving the quality of the lesions delivered. The results indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion, a reduction in intraservice times is logical for performing this procedure. The societies support the resurvey data and stand behind the 25th survey value.

While we recognize that in some ways the resurvey may be viewed as a failure, we believe the general consistency with the initial survey—demonstrating reductions in intraservice time—provides insights and a foundation to develop final recommendations for this family. First, with the additional information and tactics taken in the resurvey, we have no reason to believe respondents failed to understand the bundling that has occurred. Rather, we now have confidence that in the survey and the survey-based recommendations we make. Second, in digesting the data from the two surveys, we believe the reductions in time can, in fact, be explained by evolutions in technology and service dispersion, as discussed above. We can speak to this in more detail if helpful. Finally, the resurvey does provide a viable path forward for valuation, as the survey 25th-percentile work RVUs proceed in a reasonable progression that align with other services in the fee schedule. We recognize these recommendations produce an increase in intensity as the drop in time is not 1:1 proportionate with the drop in RVU. We believe that increase is best explained by the fact that several separately reported services are now bundled together, with work being done more quickly and several services being combined in a way that makes meaningful comparison to the prior intensity unhelpful.

Recommendation

During the January meeting, several RUC members questioned whether codes 93613, 93621 and 93662 should also be addressed in the recommendations for cardiac ablation services. These codes are bundled into CPT codes 93653 and/or 93656. Each was recently surveyed by the specialties and the RUC in 2017, 2020, 2019, respectively. **As such, the societies recommend affirming the recent times and RVUs of these recently valued codes, as they remain separate in CPT for use in concert with other CPT codes.**

Therefore, for code 93653 the **societies recommend, the survey 25th of RVW of 15.00 with 49 minutes preservice time from package 4 with 14 minutes removed, 120 minutes intraservice time from the survey median, and 30 minutes postservice time with 3 minutes removed from package 9B**. This logically aligns with the KRS 93580 in terms of IWPUT, total time, and intraservice time. Survey respondents felt 93580 was less complex and had a shorter preservice time than 93653. This recommendation also produces a work RVU savings from the current, component-coded services. The survey 25th percentile recommendation is further supported, as results from the original RUC survey and comparison to other codes (37227, 33340) from the fee schedule, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93653, 93613, 93621

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 63642
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twicethe Medicare-based claims volume.

Specialty Cardiac electrophysiology Frequency 50022 Percentage 78.59 %

Specialty Cardiology Frequency 11902 Percentage 18.70 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
31,821 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019e Medicare-based claims.

Specialty Cardiac electrophysiology Frequency 25009 Percentage 78.59 %

Specialty Cardiology Frequency 5951 Percentage 18.70 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93653

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93654 Tracking Number Y2 Original Specialty Recommended RVU: **18.10**
Presented Recommended RVU: **18.10**
Global Period: 000 Current Work RVU: **19.75** RUC Recommended RVU: **18.10**

CPT Descriptor: Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording,left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed
(Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old male with a history of New York Heart Association Class III heart failure due to ischemic dilated cardiomyopathy (ef 25%) and prior myocardial infarction presents with recurrent implantable cardioverter-defibrillator (icd) therapies for drug-refractory ventricular tachycardia.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and ventricular tachycardia ablation are explained to the patient and the patient's family. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory testing, medications, and changes in heath are reviewed. Informed consent is obtained. Direct current cardioversion/defibrillation, electrophysiology (EP), and ablation equipment is confirmed to be present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Three-dimensional mapping equipment is tested and confirmed to be functioning normally.

Description of Intra-Service Work: Local analgesia is administered. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed and/or transiently deactivated at the start of the case so as to minimize adverse consequences resulting from electromagnetic interference from radiofrequency current application.

Venous access is obtained. Arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle is obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. Papillary muscles are also recorded in the three-dimensional anatomical ultrasound map. Pacing and sensing is performed in the right atrium and right ventricle. His bundle recording is obtained. Refractory periods are measured. Attempts at ventricular tachycardia induction are performed via burst pacing, decremental pacing, and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple ventricular sites.
To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access

if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Once an arrhythmia is induced, pacing maneuvers are performed to elucidate the mechanism of the ventricular tachycardia. During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer mapping system to assist in identifying the arrhythmia circuit, localizing the origin (for focal arrhythmias) or the critical isthmus (reentrant arrhythmias). The 3D mapping system is calibrated, and recordings are made during sinus rhythm (to identify normal activation and location of scar) and during each distinct arrhythmia. The physician then analyzes the computer-generated map, ensuring that electrograms are annotated correctly and that the display parameters are correct for the specific arrhythmia being mapped. Based upon the data from the 3D mapping system, endocardial electrograms, surface ECG and the response of the SVT to pacing maneuvers, the ablation catheter is advanced to the point of earliest activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Radiofrequency (or cryo) ablation is then performed. If initial mapping in one chamber does not lead to complete identification of the essential arrhythmia circuit (either based on analysis of the map or based on incomplete ablation result, then the mapping catheter(s) is/are moved into another cardiac chamber and an additional 3D map is generated to aid in diagnosis; this is repeated until the arrhythmia mechanism is fully characterized and ablation is deemed completely successful. Occasionally mapping of the epicardial surface of the heart is necessary. A final report that includes the mapping procedure and findings is prepared.

The electrical activation sequence is mapped with the three-dimensional electroanatomical mapping system and activation timing is superimposed upon the three-dimensional image previously obtained. Anticoagulation is administered once catheters have been placed on the left side of the heart. Once the ventricular tachycardia circuit is localized, a catheter is moved to the appropriate location or region of abnormal myocardium to deliver ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue. Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures.

Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are repeated following a 30-minute period following the conclusion of the final ablation lesion. Anticoagulation is reversed. Sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed to an active configuration with rates reprogrammed as necessary to treat any remaining arrhythmias.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family, and postprocedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93654					
Sample Size:	1036	**Resp N:**	63			
Description of Sample:	randomly selected electrophysiologists from the two societies					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	36.00	140.00
Survey RVW:	9.50	18.10	**24.38**	29.71	46.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	5.00	170.00	**200.00**	240.00	515.00

Immediate Post Service-Time:	**35.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93654	**Recommended Physician Work RVU: 18.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**200.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**33.00**	**33.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93590	000	21.70	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 21 **% of respondents:** 33.3 **%**

Number of respondents who choose 2nd Key Reference Code: 20 **% of respondents:** 31.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 93654	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: **93590**
Median Pre-Service Time	58.00	30.00	58.00
Median Intra-Service Time	200.00	120.00	135.00
Median Immediate Post-service Time	33.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**291.00**	**210.00**	**223.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	5%	24%	71%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	5%	95%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	5%	95%
Physical effort required	5%	24%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	10%	90%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	15%	10%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	10%	90%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	18%	85%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	15%	85%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the codes are

re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653 and 93656, and were tasked in surveying the other codes in the family: 93654, 93655, and 93657. The societies surveyed members late 2020 and presented data in January 2021. Due to inconsistencies in the survey data and in order to better convey the bundled services to respondents, the ACC and HRS resurveyed members March 2021.

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. To remedy the above-described shortcomings, the societies work with the Research Subcommittee to deploy several tactics to obtain more consistent survey results. First, fake/dummy codes were used in the survey so that respondents would not presume to know the code descriptors. Second, additional language noting the bundling was included in the survey invitation. Third, respondents were required to attest they had read and understood the new language before completing the survey.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 33% of respondents. Approximately 95% of the respondents indicated that 93654 was more complex. The second reference code was 93590 for percutaneous transcatheter closure of paravalvular leak. It was selected by approximately 32% of respondents. About 85% of the respondents indicated that 93654 was more intense/complex overall.

Rationale

In reviewing the resurvey data to develop work recommendations, the expert panel believes the data does accurately reflect the newly bundled services, 93653 and 93656. The societies believe the technological advances made in patient care indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion have clearly altered the way this service is provided. Over time, the mapping systems have improved, now providing much more detailed and accurate anatomical and electrical activation mapping, often removing the need for fluoroscopy completely. Catheter technology has advanced, providing real-time assessment of the quality of contact between the catheter tip and the endocardial tissue. Last, the 3D mapping systems in conjunction with new catheter technology are now able to provide real-time assessment of the quality of radiofrequency ablation lesion formation. This feature has allowed operators to significantly shorten the duration of each radiofrequency application while also improving the quality of the lesions delivered. The results indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion, a reduction in intraservice times is logical for performing this procedure. The societies support the resurvey data and stand behind the 25th survey value.

While we recognize that in some ways the resurvey may be viewed as a failure, we believe the general consistency with the initial survey—demonstrating reductions in intraservice time—provides insights and a foundation to develop final recommendations for this family. First, with the additional information and tactics taken in the resurvey, we have no reason to believe respondents failed to understand the bundling that has occurred. Rather, we now have confidence that in the survey and the survey-based recommendations we make. Second, in digesting the data from the two surveys, we believe the reductions in time can, in fact, be explained by evolutions in technology and service dispersion, as discussed above. We can speak to this in more detail if helpful. Finally, the resurvey does provide a viable path forward for valuation, as the survey 25th-percentile work RVUs proceed in a reasonable progression that align with other services in the fee schedule. We recognize these recommendations produce an increase in intensity as the drop in time is not 1:1 proportionate with the drop in RVU. We believe that increase is best explained by the fact that several separately reported services are now bundled together, with work being done more quickly and several services being combined in a way that makes meaningful comparison to the prior intensity unhelpful.

Recommendation

During the January meeting, several RUC members questioned whether codes 93613, 93621 and 93662 should also be addressed in the recommendations for cardiac ablation services. These codes are bundled into CPT codes 93653 and/or 93656. Each was recently surveyed by the specialties and the RUC in 2017, 2020, 2019, respectively. **As such, the societies recommend affirming the recent times and RVUs of these recently valued codes, as they remain separate in CPT for use in concert with other CPT codes.**

Therefore, for code 93654 the **societies recommend the survey 25th RVU of 18.10 with 58 minutes preservice time from package 4 with five minutes removed, 200 minutes intraservice time from the survey median, and 33 minutes postservice time from Post Service Package 9B**. This value builds some increment from 93653 that accounts for longer time. The survey 25th percentile recommendation is further supported by results from the original RUC survey and comparison codes as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93654

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 11935 Percentage 77.00 %

Specialty Cardiology Frequency 3147 Percentage 20.30 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,750
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019 eMedicare based claims.

Specialty Cardiac electrophysiology Frequency 5968 Percentage 77.00 %

Specialty Cardiology Frequency 1573 Percentage 20.29 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93654

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93655 Tracking Number Y3 Original Specialty Recommended RVU: **7.00**
Presented Recommended RVU: **7.00**
Global Period: ZZZ Current Work RVU: **7.50** RUC Recommended RVU: **7.00**

CPT Descriptor: Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia
(List separately in addition to code for primary procedure)
(Use 93655 in conjunction with 93653, 93654, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female has undergone successful ablation of her atrial supraventricular tachycardia (SVT) focus (reported separately). Attempts to re-induce that arrhythmia reveal an additional atrial focus (also reported separately). A decision is made to ablate this additional focus following its discovery.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A full electrophysiologic study and ablation procedure has been performed. Diagnostic and ablative electrophysiology (EP) catheters are in cardiac chambers. During the course of the post-ablation electrophysiologic evaluation, a second (or greater) arrhythmia is identified. For example, if the primary tachycardia ablated was atrioventricular (AV) nodal reentrant tachycardia and during post ablation testing, an atrial tachycardia, atrial flutter, or accessory pathway with orthotropic reentry tachycardia is identified, this would be considered a separate mechanism of tachycardia. Pacing maneuvers are performed to define the mechanism(s) of the new tachycardia(s). Mapping is performed to define the optimal ablation site or sites that are distinct from the initial ablation site(s). Catheter ablation of this distinct mechanism of tachycardia is performed at its origin. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer-assisted mapping system to localize the arrhythmia origin. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is

engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures. Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93655					
Sample Size:	1036	**Resp N:**	63			
Description of Sample:	randomly selected electrophysiologists from the two societies					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	11.00	**25.00**	50.00	120.00
Survey RVW:	3.28	7.00	**8.00**	10.00	20.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	14.00	45.00	**60.00**	69.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93655	**Recommended Physician Work RVU: 7.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
35306	ZZZ	9.25	**RUC Time**

CPT Descriptor Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37237	ZZZ	4.25	**RUC Time**

CPT Descriptor Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93592	ZZZ	8.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 23.8 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 20.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 93655	Top Key Reference CPT Code: 35306	2nd Key Reference CPT Code: 37237
Median Pre-Service Time	0.00	0.00	1.00
Median Intra-Service Time	60.00	90.00	45.00
Median Immediate Post-service Time	0.00	0.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**90.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	40%	53%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	0%	71%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	54%	31%	15%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	16%	31%	53%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the codes are

re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653 and 93656, and were tasked in surveying the other codes in the family: 93654, **93655,** and 93657. The societies surveyed members late 2020 and presented data in January 2021. Due to inconsistencies in the survey data and in order to better convey the bundled services to respondents, the ACC and HRS resurveyed members March 2021.

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. To remedy the above-described shortcomings, the societies work with the Research Subcommittee to deploy several tactics to obtain more consistent survey results. First, fake/dummy codes were used in the survey so that respondents would not presume to know the code descriptors. Second, additional language noting the bundling was included in the survey invitation. Third, respondents were required to attest they had read and understood the new language before completing the survey.

The key reference code is 35306 for thromboendarterectomy. It was selected by approximately 24% of respondents. 60% of the respondents indicated that 93655 was more complex. The second reference code was 32737 for Transcatheter placement of an intravascular stent(s). It was selected by approximately 20% of respondents. About 46% of the respondents indicated that 93655 was more intense/complex overall.

Rationale

In reviewing the survey data to develop work recommendations, the expert panel believes the data accurate reflects the newly bundled services, 93653 and 93656. The societies believe the technological advances made in patient care indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion have clearly altered the way this service is provided. Over time, the mapping systems have improved, now providing much more detailed and accurate anatomical and electrical activation mapping, often removing the need for fluoroscopy completely. Catheter technology has advanced, providing real-time assessment of the quality of contact between the catheter tip and the endocardial tissue. Last, the 3D mapping systems in conjunction with new catheter technology are now able to provide real-time assessment of the quality of radiofrequency ablation lesion formation. This feature has allowed operators to significantly shorten the duration of each radiofrequency application while also improving the quality of the lesions delivered. The results indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion, a reduction in intraservice times is logical for performing this procedure. The societies support the resurvey data and stand behind the 25th survey value.

While we recognize that in some ways the resurvey may be viewed as a failure, we believe the general consistency with the initial survey—demonstrating reductions in intraservice time—provides insights and a foundation to develop final recommendations for this family. First, with the additional information and tactics taken in the resurvey, we have no reason to believe respondents failed to understand the bundling that has occurred. Rather, we now have confidence that in the survey and the survey-based recommendations we make. Second, in digesting the data from the two surveys, we believe the reductions in time can, in fact, be explained by evolutions in technology and service dispersion, as discussed above. We can speak to this in more detail if helpful. Finally, the resurvey does provide a viable path forward for valuation, as the survey 25th-percentile work RVUs proceed in a reasonable progression that align with other services in the fee schedule. We recognize these recommendations produce an increase in intensity as the drop in time is not 1:1 proportionate with the drop in RVU. We believe that increase is best explained by the fact that several separately reported services are now bundled together, with work being done more quickly and several services being combined in a way that makes meaningful comparison to the prior intensity unhelpful.

Recommendation

During the January meeting, several RUC members questioned whether codes 93613, 93621 and 93662 should also be addressed in the recommendations for cardiac ablation services. These codes are bundled into CPT codes 93653 and/or 93656. Each was recently surveyed by the specialties and the RUC in 2017, 2020, 2019, respectively. **As such, the societies recommend affirming the recent times and RVUs of these recently valued codes, as they remain separate in CPT for use in concert with other CPT codes.**

While this code descriptor did not change, its use as an additional ablation with a new base code that includes 3D mapping and left-atrial pacing, changing the service. The same 3D mapping and left-atrial pacing elements that were bundled into 93653 should now typically be considered to be included into this service, since those elements occur throughout the additional ablation. Therefore, for code 93655 the **societies recommend, the 25th survey value of 7.00 RVW with 60 minutes intraservice time**. This is sensibly below the KRS. This value also brings the IWPUT for 93655 in nearly identical alignment with that of 93653. This recommended value can also be supported by comparison to the percutaneous transcatheter closure of paravalvular leak, 93592; open iliac artery exposure, 34820; and transcatheter intracardiac shunt creation, 33746, as seen in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93655

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 62294
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 50085 Percentage 80.40 %

Specialty Cardiology Frequency 10715 Percentage 17.20 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
31,821 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects Medicare based claims.

Specialty Cardiac electrophysiology Frequency 25042 Percentage 78.69 %

Specialty Cardiology Frequency 5474 Percentage 17.20 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93655

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93656 Tracking Number Y4 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 000 Current Work RVU: **19.77** RUC Recommended RVU: **17.00**

CPT Descriptor: Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and his bundle recording, when performed
(Do not report 93656 in conjunction with 93279, 93280, 93281, 93282, 93283, 93284, 93286, 93287, 93288, 93289, 93462, 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93653, 93654, 93662)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male with a history of hypertension has recurrent atrial fibrillation. despite rate and rhythm control with antiarrhythmic drugs, he remains symptomatic. a comprehensive electrophysiologic evaluation with transeptal catheterization and catheter ablation by pulmonary vein isolation for atrial fibrillation is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: A three-dimensional imaging study such as cardiac magnetic resonance imaging (MRI) or computed tomography (CT) scanning may be obtained prior to the procedure to assess atrial size and for pulmonary vein anatomic variants. The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and atrial fibrillation ablation are explained to the patient and the patient's family. Management of antiarrhythmic medications is communicated to the patient. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory, medications, and change in health status are reviewed with careful attention to the degree of anticoagulation. Informed consent is obtained. Direct current cardioversion/defibrillation, electrophysiology (EP), and ablative equipment is confirmed to be present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested.

Description of Intra-Service Work: Local analgesia is administered. Venous access is obtained. Arterial access to monitor blood pressure and to retrograde aortic access to the left ventricle may be obtained. By means of the venous access sites, multi-electrode catheters are positioned in specific cardiac chambers. An intracardiac echocardiographic probe is advanced into the heart and imaging of the heart and pericardium is performed: specific structures visualized include: right atrium, tricuspid valve, right ventricle, left atrium, aortic valve, left ventricle, pulmonary veins (left upper, left lower, right upper, right lower), pericardium, superior vena cava, coronary sinus. Intracardiac echocardiography may be used to guide catheter manipulation, guide transseptal puncture, provide visualization of catheter contact during mapping and ablation, and observe for complications throughout the procedure. The intracardiac echo catheter may be placed into the left atrium or right ventricle for additional imaging planes. One or two transseptal catheterizations are performed to achieve access and facilitate placement of both a circular mapping catheter and an ablation catheter in the left atrium.

Additional anticoagulation is administered. Level of anticoagulation is monitored throughout the procedure and additional anticoagulation is administered as needed. Conduction intervals and refractory periods are measured and arrhythmia induction attempted. His bundle recording and ventricular pacing and sensing are performed. A mapping catheter is passed into the left atrium and pulmonary vein conduction is assessed and recorded. Selective venography of the pulmonary veins may be performed to define anatomy. A high definition 3D anatomical map of the chamber(s) of interest is generated. Voltage and relative electrical activation in the arrhythmia and/or sinus may be performed to identify normal activation, location of scar, and mechanism of arrhythmia. Importation, segmentation, and/or registration to the three dimensional map of a MRI/CT scan may be performed. High output pacing is performed to prevent and/or monitor for phrenic nerve damage during ablation. Catheter ablation is then performed to achieve pulmonary vein isolation. Point lesions or balloon administered lesions encircling the pulmonary vein region are created that guided by anatomical mapping and electrical signals provided by a circular mapping catheter. Pulmonary vein isolation, as measured by the circular mapping catheter as well as loss of tissue voltage and tissue pacing capture are the measured endpoints.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer-assisted mapping system to localize the arrhythmia origin. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

Throughout the ablation the patient is monitored hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, thrombus formation, or damage to cardiac or vascular structures, including meticulous monitoring for lesion delivery within the pulmonary vein or close to the esophagus. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the pulmonary veins demonstrate recovery of conduction, then repeat mapping and ablation are performed as described above. These steps are repeated until the pulmonary veins are rendered durably isolated. Once electrophysiology testing and ablation are completed, anticoagulation is reversed. Post procedure, sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family and a postprocedure assessment is performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93656					
Sample Size:	1036	**Resp N:**	61			
Description of Sample:	randomly selected electrophysiologists from the two societies					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	30.00	**60.00**	100.00	214.00	
Survey RVW:	8.85	17.00	**21.50**	28.48	46.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	4.00	150.00	**180.00**	210.00	380.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93656	**Recommended Physician Work RVU: 17.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93590	000	21.70	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 37.7 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 27.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93656	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: **93590**
Median Pre-Service Time	63.00	30.00	58.00
Median Intra-Service Time	210.00	120.00	135.00
Median Immediate Post-service Time	33.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**306.00**	**210.00**	**223.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	17%	35%	48%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	5%	95%
Physical effort required	10%	29%	59%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	26%	70%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	12%	23%	65%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	18%	82%
Physical effort required	0%	29%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	18%	82%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the

codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653, 93654, 93655, 93656, 93657. As indicated in the summary spreadsheet, revised 93653 is now a more comprehensive, bundled service that includes the work of 3D mapping (93613) and left atrial pacing/recording (93621). The societies surveyed members late 2020 and presented data in January 2021. Due to inconsistencies in the survey data and in order to better convey the bundled services to respondents, the ACC and HRS resurveyed members March 2021.

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. To remedy the above-described shortcomings, the societies work with the Research Subcommittee to deploy several tactics to obtain more consistent survey results. First, fake/dummy codes were used in the survey so that respondents would not presume to know the code descriptors. Second, additional language noting the bundling was included in the survey invitation. Third, respondents were required to attest they had read and understood the new language before completing the survey.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 38% of respondents. 83% of the respondents indicated that 93656 was more complex. The second reference code was 93590 percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve. It was selected by approximately 27% of respondents. About 88% of the respondents indicated that 93656 was more intense/complex overall.

Rationale

In reviewing the survey data to develop work recommendations, the expert panel believes the data accurate reflects the newly bundled services, 93653 and 93656. The societies believe the technological advances made in patient care indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion have clearly altered the way this service is provided. Over time, the mapping systems have improved, now providing much more detailed and accurate anatomical and electrical activation mapping, often removing the need for fluoroscopy completely. Catheter technology has advanced, providing real-time assessment of the quality of contact between the catheter tip and the endocardial tissue. Last, the 3D mapping systems in conjunction with new catheter technology are now able to provide real-time assessment of the quality of radiofrequency ablation lesion formation. This feature has allowed operators to significantly shorten the duration of each radiofrequency application while also improving the quality of the lesions delivered. The results indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion, a reduction in intraservice times is logical for performing this procedure. The societies support the resurvey data and stand behind the 25th survey value.

While we recognize that in some ways the resurvey may be viewed as a failure, we believe the general consistency with the initial survey—demonstrating reductions in intraservice time—provides insights and a foundation to develop final recommendations for this family. First, with the additional information and tactics taken in the resurvey, we have no reason to believe respondents failed to understand the bundling that has occurred. Rather, we now have confidence that in the survey and the survey-based recommendations we make. Second, in digesting the data from the two surveys, we believe the reductions in time can, in fact, be explained by evolutions in technology and service dispersion, as discussed above. We can speak to this in more detail if helpful. Finally, the resurvey does provide a viable path forward for valuation, as the survey 25th-percentile work RVUs proceed in a reasonable progression that align with other services in the fee schedule. We recognize these recommendations produce an increase in intensity as the drop in time is not 1:1 proportionate with the drop in RVU. We believe that increase is best explained by the fact that several separately reported services are now bundled together, with work being done more quickly and several services being combined in a way that makes meaningful comparison to the prior intensity unhelpful.

Recommendation

During the January meeting, several RUC members questioned whether codes 93613, 93621 and 93662 should also be addressed in the recommendations for cardiac ablation services. These codes are bundled into CPT codes 93653 and/or 93656. Each was recently surveyed by the specialties and the RUC in 2017, 2020, 2019, respectively. **As such, the societies recommend affirming the recent times and RVUs of these recently valued codes, as they remain separate in CPT for use in concert with other CPT codes.**

Therefore, for code 93656 the **societies recommend, survey 25th percentile of 17.00 RVW with 53 minutes preservice time from package 4 with 10 minutes removed, 180 minutes intraservice time from the survey median, and 30 minutes postservice time from package 9B with 3 minutes removed**. This recommendation produces a work RVU savings from the current, component-coded services. The survey 25th percentile recommendation is further supported summary spreadsheet and results from the original RUC survey support similar values.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93656

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 106654
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 92256 Percentage 86.50 %

Specialty Cardiology Frequency 13972 Percentage 13.10 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 53,327 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects Medicare based claims.

Specialty Cardiac electrophysiology Frequency 46128 Percentage 86.50 %

Specialty Cardiology Frequency 6986 Percentage 13.10 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93656

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93657 Tracking Number Y5 Original Specialty Recommended RVU: **7.00**
Presented Recommended RVU: **7.00**
Global Period: ZZZ Current Work RVU: **7.50** RUC Recommended RVU: **7.00**

CPT Descriptor: Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation
(List separately in addition to code for primary procedure)
(Use 93657 in conjunction with 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male has symptomatic atrial fibrillation refractory to medical therapy. An electrophysiology (EP) study and ablation are performed to achieve pulmonary vein isolation (reported separately). Despite demonstration of electrical isolation of the pulmonary veins, atrial fibrillation continues.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A full electrophysiologic study and ablation procedure has been performed for atrial fibrillation. Diagnostic and ablation catheters are present in cardiac chambers. Pulmonary vein isolation has been accomplished. An intracardiac echocardiographic probe has been advanced into the heart and imaging of the heart and pericardium is performed. Intracardiac echocardiography may be used to guide catheter manipulation, guide transseptal puncture, guide catheter manipulation and observe for complications throughout the procedure. Due to the presence of non-pulmonary vein sources of atrial fibrillation, additional non-pulmonary vein ablation lesions are created. These additional ablation lesions may contain any or all of the following: 1) Regions of fractionated potentials are mapped and ablated outside the pulmonary vein area. 2) linear lesions are created along the roof, mitral isthmus, or septal aspect of the left atrium. 3) Non-pulmonary vein focal sources of atrial fibrillation induction are induced, localized, and ablated. These locations may include areas of the left atrium, right atrium, superior vena cava, or coronary sinus. During the delivery of ablation energy, continuous monitoring for hemodynamic instability, arrhythmias, embolic events, and injury to the esophagus is performed.

During the course of these additional ablation lesions, an advanced 3D computer-assisted mapping system is used to facilitate identification of sites to target for catheter ablation as well as to record sites of lesions to allow the operator to create linear lesions. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

Appropriate post ablation attempts at reeducation and observation for 30-minutes are performed. Following restoration of sinus rhythm, conduction intervals are measured and arrhythmia induction is re-attempted over a 30-minute period following the last ablation lesion. If the target site demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the target site is rendered durably suppressed or the line demonstrates durable conduction block.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93657					
Sample Size:	1036	**Resp N:**	61			
Description of Sample:	electrophysiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**25.00**	45.00	120.00
Survey RVW:	3.00	7.00	**8.25**	10.00	26.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	45.00	**60.00**	84.00	150.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93657	**Recommended Physician Work RVU: 7.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
35306	ZZZ	9.25	**RUC Time**

CPT Descriptor Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37237	ZZZ	4.24	**RUC Time**

CPT Descriptor Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coaronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93592	ZZZ	8.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 37.7 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 27.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93657	Top Key Reference CPT Code: 35306	2nd Key Reference CPT Code: 37237
Median Pre-Service Time	0.00	0.00	1.00
Median Intra-Service Time	60.00	90.00	45.00
Median Immediate Post-service Time	0.00	0.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**90.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	17%	35%	48%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	5%	95%
Physical effort required	10%	39%	61%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	26%	70%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	12%	24%	64%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	18%	82%
Physical effort required	0%	30%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	18%	82%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the codes are

re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653, 93654, 93655, 93656, **93657.** The societies surveyed members late 2020 and presented data in January 2021. Due to inconsistencies in the survey data and in order to better convey the bundled services to respondents, the ACC and HRS resurveyed members March 2021.

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. To remedy the above-described shortcomings, the societies work with the Research Subcommittee to deploy several tactics to obtain more consistent survey results. First, fake/dummy codes were used in the survey so that respondents would not presume to know the code descriptors. Second, additional language noting the bundling was included in the survey invitation. Third, respondents were required to attest they had read and understood the new language before completing the survey.

The key reference code is 35306 for thromboendarterectomy. It was selected by approximately 30% of respondents. About 66% of the respondents indicated that 93657 was more complex. The second reference code was 32737 for Transcatheter placement of an intravascular stent(s). It was selected by approximately 21% of respondents. About 53% of the respondents indicated that 93657 was more intense/complex overall.

Rationale

In reviewing the survey data to develop work recommendations, the expert panel believes the data accurate reflects the newly bundled services, 93653 and 93656. The societies believe the technological advances made in patient care indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion have clearly altered the way this service is provided. Over time, the mapping systems have improved, now providing much more detailed and accurate anatomical and electrical activation mapping, often removing the need for fluoroscopy completely. Catheter technology has advanced, providing real-time assessment of the quality of contact between the catheter tip and the endocardial tissue. Last, the 3D mapping systems in conjunction with new catheter technology are now able to provide real-time assessment of the quality of radiofrequency ablation lesion formation. This feature has allowed operators to significantly shorten the duration of each radiofrequency application while also improving the quality of the lesions delivered. The results indicate survey respondents understood that 3D mapping and left atrial pacing were now inherent to 93653. After nearly a decade and many changes in technology and broader service dispersion, a reduction in intraservice times is logical for performing this procedure. The societies support the resurvey data and stand behind the 25th survey value.

While we recognize that in some ways the resurvey may be viewed as a failure, we believe the general consistency with the initial survey—demonstrating reductions in intraservice time—provides insights and a foundation to develop final recommendations for this family. First, with the additional information and tactics taken in the resurvey, we have no reason to believe respondents failed to understand the bundling that has occurred. Rather, we now have confidence that in the survey and the survey-based recommendations we make. Second, in digesting the data from the two surveys, we believe the reductions in time can, in fact, be explained by evolutions in technology and service dispersion, as discussed above. We can speak to this in more detail if helpful. Finally, the resurvey does provide a viable path forward for valuation, as the survey 25th-percentile work RVUs proceed in a reasonable progression that align with other services in the fee schedule. We recognize these recommendations produce an increase in intensity as the drop in time is not 1:1 proportionate with the drop in RVU. We believe that increase is best explained by the fact that several separately reported services are now bundled together, with work being done more quickly and several services being combined in a way that makes meaningful comparison to the prior intensity unhelpful.

Recommendation
During the January meeting, several RUC members questioned whether codes 93613, 93621 and 93662 should also be addressed in the recommendations for cardiac ablation services. These codes are bundled into CPT codes 93653 and/or 93656. Each was recently surveyed by the specialties and the RUC in 2017, 2020, 2019, respectively. **As such, the societies recommend affirming the recent times and RVUs of these recently valued codes, as they remain separate in CPT for use in concert with other CPT codes.**

While this code descriptor did not change, its use as an additional ablation with a new base code that includes 3D mapping and intracardiac echo, changing the service. The same 3D mapping and intracardiac echo elements that were bundled into 93656 should now typically be considered to be included into this service, since those elements occur throughout the

additional ablation. Therefore, for code 93657 the **societies recommend the survey 25th percentile of 7.00 RVU with 60 minutes intraservice time**. This value fits well with comparators noted in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93657, 93613, 93662

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 43919
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is twice much as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 36000 Percentage 81.96 %

Specialty Cardiology Frequency 8000 Percentage 18.21 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,959 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019e Medicare based claims.

Specialty Cardiac electrophysiology Frequency 18000 Percentage 81.97 %

Specialty Cardiology Frequency 4000 Percentage 18.21 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93657

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Cardiac Ablation Services Bundling

TAB: 7

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	2002	20	0.133	0.086			17.97			210	30					120			60					
2nd REF	33340	000	Percutaneous transcatheter closure of the left atrial	2016	16	0.136	0.077			14.00			183	40	3	20			90			30					
CURRENT	93653	000	Comprehensive electrophysiologic evaluation	2012		0.075	0.062			14.75			239	23	1	5			180			30					
CURRENT	93613	ZZZ	Intracardiac electrophysiologic 3-dimensional mapping (List	2017		0.058	0.058			5.23			90						90								
CURRENT	93621	ZZZ	Comprehensive electrophysiologic evaluation	2001 (2020 for CPT 2022))		0.070	0.070			2.10			30						30								
OLD SVY	93653	000	Comprehensive electrophysiologic evaluation		74	0.130	0.079	8.00	15.00	18.49	22.76	30.00	235	50	15	15	60	120	125	180	240	30	0	27	40	60	110
Interim Rec from Feb21	93653	000	Comprehensive electrophysiologic evaluation			0.134	0.087			18.49			213	40	3	15			125			30					
RESURVEY with Proxy Code #	936X1	000	Comprehensive electrophysiologic evaluation including with insertion and		62	0.135	0.085	7.25	15.00	18.00	23.25	37.00	211	31	15	15	3	120	120	150	360	30	0	25	40	50	200
REC	93653	000	Comprehensive electrophysiologic evaluation including with insertion and repositioning of multiple			0.112	0.075			15.00			199	31	3	15			120			30					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	2002	21	0.133	0.086			17.97			210	30					120			60					
2nd REF	93590	000	Percutaneous transcatheter closure of paravalvular leak:	2016	20	0.148	0.097			21.70			223	40	3	15			135			30					
CURRENT	93654	000	Comprehensive electrophysiologic evaluation	2012		0.076	0.064			19.75			309	23	1	5			240			40					
OLD SVY	93654	000	Comprehensive electrophysiologic evaluation		73	0.092	0.065	10.00	20.00	25.00	30.00	50.00	387	62	20	20	60	180	240	282	480	45	0	10	20	30	200
Interim Rec from Feb21	93654	000	Comprehensive electrophysiologic evaluation			0.075	0.059			19.75			336	40	3	20			240			33					
RESURVEY with Proxy Code #	936X2	000	Comprehensive electrophysiologic evaluation with insertion and		63	0.111	0.080	9.50	18.10	24.38	29.71	46.00	305	40	15	15	5	170	200	240	515	35	0	10	20	36	140
REC	93654	000	Comprehensive electrophysiologic evaluation with insertion and			0.081	0.062			18.10			291	40	3	15			200			33					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	35306	ZZZ	Thromboendarterectomy, including patch graft, if	2006	15	0.103	0.103			9.25			90	0					90			0					
2nd REF	37237	ZZZ	Transcatheter placement of an intravascular stent(s) (except	2013	13	0.093	0.090			4.25			47	1					45			1					
CURRENT	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of	2012		0.083	0.083			7.50			90						90								
OLD SVY	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of		74	0.167	0.167	4.00	8.00	10.00	10.89	20.00	60				16	45	60	90	240		0	10	28	50	300
Interim Rec from Feb21	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of			0.108	0.108			6.50			60						60								
RESURVEY with Proxy Code #	936X3	ZZZ	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct		63	0.133	0.133	3.28	7.00	8.00	10.00	20.00	60				14	45	60	69	120	0	0	11	25	50	120
REC	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct			0.117	0.117			7.00			60						60								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	2002	23	0.133	0.086			17.97			210	30					120			60					
2nd REF	93590	000	Percutaneous transcatheter closure of paravalvular leak:	2016	17	0.148	0.097			21.70			223	40	3	15			135			30					
CURRENT	93656	000	Comprehensive electrophysiologic evaluation	2012		0.076	0.064			19.77			309	23	1	5			240			40					
CURRENT	93613	ZZZ	Intracardiac electrophysiologic 3-dimensional mapping (List	2017		0.058	0.058			5.23			90						90								
CURRENT	93662	ZZZ	Intracardiac echocardiography during therapeutic/diagnostic	2019		0.058	0.058			1.44			25						25								
OLD SVY	93656	000	Comprehensive electrophysiologic evaluation		74	0.103	0.071	10.00	20.00	24.20	27.92	43.00	342	50	19	20	60	180	210	240	360	43	0	38	75	108	300
Interim Rec from Feb21	93656	000	Comprehensive electrophysiologic evaluation			0.086	0.065			20.00			306	40	3	20			210			33					
RESURVEY with Proxy Code #	936X4	000	Comprehensive electrophysiologic evaluation including transseptal		61	0.109	0.078	8.85	17.00	21.50	28.48	46.00	275	35	15	15	4	150	180	210	380	30	0	30	60	100	214
REC	93656	000	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and			0.085	0.065			17.00			263	35	3	15			180			30					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	35306	ZZZ	Thromboendarterectomy, including patch graft, if	2006	18	0.103	0.103			9.25			90						90								
2nd REF	37237	ZZZ	Transcatheter placement of an intravascular stent(s) (except	2013	13	0.093	0.090			4.25			47	1					45			1					
CURRENT	93657	ZZZ	Additional linear or focal intracardiac catheter ablation	2012		0.083	0.083			7.50			90						90								
OLD SVY	93657	ZZZ	Additional linear or focal intracardiac catheter ablation		74	0.151	0.151	4.00	8.00	9.05	10.21	22.00	60				20	50	60	90	240		0	10	28	50	300
Interim Rec from Feb21	93657	ZZZ	Additional linear or focal intracardiac catheter ablation			0.108	0.108			6.50			60						60								
RESURVEY with Proxy Code #	93657	ZZZ	Additional linear or focal intracardiac catheter ablation of the left or right atrium for		61	0.138	0.138	3.00	7.00	8.25	10.00	26.00	60				7	45	60	84	150	0	0	10	25	45	120
REC	93657	ZZZ	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation			0.117	0.117			7.00			60	0					60			0					

CURRENT & Jan 2017 RUC Rec	93613	ZZZ	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)			0.058	0.058			5.23			90						90								

Affirm previous January 2017 RUC recommendations

CURRENT	93621	ZZZ	Comprehensive electrophysiologic evaluation			0.070	0.070			2.10			30						30								
Oct 2020 RUC Recommendation	93621	ZZZ	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with			0.088	0.088			1.75			20						20								

Affirm previous October 2020 RUC recommendations

CURRENT	93662	ZZZ	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging			0.058	0.058			1.44			25						25								
May 2019 RUC Recommendation	93662	ZZZ	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to			0.101	0.101			2.53			25						25								

Affirm previous April 2019 RUC recommendations

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 7 Practice Expense

Dear Dr. Manaker:

Tab 7 on the April 2021 RUC agenda addresses five codes, SVT ablation, atrial fibrillation ablation, and the entire family of codes (93653-93657). Additionally, the Tab also includes three add-on codes 93613, 93621, and 93662. These services are provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 7.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,
Richard Wright, MD
ACC RUC Advisor
Mark Schoenfeld, MD
HRS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS High Expenditure Procedures

January 2017

Intracardiac 3D Mapping Add-On

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

93613 ***Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 47 cardiologists and determined that the survey 25th percentile work RVU of 5.23 appropriately accounts for the work required to perform this service. The RUC recommends 90 minutes intra-service time. The RUC determined that the decrease in the recommended work RVU appropriately corresponds to the decrease in intra-service work. The RUC edited the description of work to delete "remove the catheter and obtaining hemostasis" as this is associated with the primary procedure. The RUC compared the surveyed code to the top key reference service 93609 *Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure*) (PC work RVU = 4.99 and 90 minutes intra-service time) and determined that this service was slightly more intense and complex on all measures examined. The RUC also compared the surveyed code to the second top key reference code 93655 *Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)* (work RVU = 7.50 and 90 minutes intra-service time) and determined that code 93655 is more intense than the surveyed code because it entails the initiation and prolonged observation (to allow for mapping, the surveyed code) of arrhythmias that are potentially dangerous and/or hemodynamically unstable with increased risk to the patient and thereafter requires ablation which in and of itself carries precision and risk- it requires greater intensity to perform the complex initiation of arrhythmias and to manage such patients while these arrhythmias are being mapped in order to allow for the subsequent ablation. In addition, any patient who has more than one arrhythmia focus becomes exponentially complex. The diagnostic maneuvers, mapping and ablation skills needed to successfully treat a second focus are significant. Not all arrhythmia foci are created equally. Patients who have more than one focus tend to have significant scar tissue. Mapping the circuit of the arrhythmia is particularly challenging because distinguishing between partly viable tissue and complete scare requires a very dense map (meaning many data points must be acquired and correctly interpreted and annotated on the map).

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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

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

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	ZZZ	5.23

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93613 Tracking Number Original Specialty Recommended RVU: **5.23**
Presented Recommended RVU: **5.23**
Global Period: ZZZ RUC Recommended RVU: **5.23**

CPT Descriptor: Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female is undergoing radiofrequency ablation (reported separately) to treat atrial tachycardia. Atrial tachycardia is induced, with a morphology similar to the tachycardia that had been documented clinically. 3D mapping is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: During the course of an electrophysiology procedure, induce an arrhythmia that requires use of an advanced three-dimensional (3D) computer-assisted mapping system to localize the arrhythmia origin. Place the mapping system in the cardiac chamber of interest using standard percutaneous techniques. Calibrate the system and make recordings during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. Display the computer-generated map, make modifications in the computer parameters and display, and identify the tachycardia origin. Move the ablation catheter to the point of early activation localized by the mapping system to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a re-entrant circuit is identified, perform entrainment mapping studies and evaluated them to confirm the catheter location is within the re-entrant circuit. Make additional mappings to confirm arrhythmia origin and study additional arrhythmias at the conclusion of the procedure. Prepare a final report and include the mapping procedure and findings.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2017		
Presenter(s):	Richard Wright, MD; Mark Schoenfeld, MD; Thad Waites, MD; David Slotwiner, MD		
Specialty(s):	ACC, HRS		
CPT Code:	93613		
Sample Size:	500	**Resp N:** 47	**Response:** 9.4 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	12.00	50.00	**100.00**	128.00	250.00
Survey RVW:	2.25	5.23	**7.00**	8.00	15.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	48.00	**90.00**	120.00	400.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93613	**Recommended Physician Work RVU: 5.23**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93609	ZZZ	4.99	**RUC Time**

CPT Descriptor Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93655	ZZZ	7.50	**RUC Time**

CPT Descriptor Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57267	ZZZ	4.88	**RUC Time**	6,947

CPT Descriptor 1 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	134,208

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
22851	ZZZ	6.70	**RUC Time**

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

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 55.3 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 27.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 93613	Top Key Reference CPT Code: 93609	2nd Key Reference CPT Code: **93655**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	90.00	90.00	90.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**90.00**	**90.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	2nd Key Ref Code
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.88	0.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.62	0.69
Urgency of medical decision making	0.42	0.15
Technical Skill/Physical Effort (Mean)		
Technical skill required	0.96	0.54

Physical effort required	0.62	0.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.19	0.00
Outcome depends on the skill and judgment of physician	0.69	0.62
Estimated risk of malpractice suit with poor outcome	0.27	0.15

INTENSITY/COMPLEXITY MEASURES	**Top Key Ref Code**	**2nd Key Ref Code**

Time Segment (Mean)

Overall intensity/complexity	0.96	0.77

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

93613 is an add-on code used with several cardiac electrophysiology evaluation and/or ablation services. It describes the work of placing the mapping system inside the heart and creating a map of the chamber to aid performance of the underlying service.

CMS identified 93613 in CY 2016 rulemaking as potentially misvalued through its high-expenditure screen. A random survey of 500 ACC and HRS members was executed with 47 completed surveys. The information obtained is used to develop the survey results in the SOR and the summary spreadsheet.

The key reference service was selected by 26 respondents. Respondents who selected atrial tachycardia mapping code 93609 as the key reference code found 93613 to be more intense/complex in every factor, as shown in the above table and the attached addendum. This comparison is reasonable, since the median survey time of 90 minutes equals the 90-minute survey time for 93609, yet respondents estimated 93613 to be more work.

At this RVU level, no comparable ZZZ MPC codes exist. The two highest MPC ZZZ codes—57267 for insertion of vaginal mesh or prosthesis for repair of pelvic floor defect and 63048 for vertebra laminectomy—are included on the SOR and summary spreadsheet. We note that both of those half as much intraservice time (45 minutes). We searched the RUC database for additional comparators and found only nine other RUC-reviewed ZZZ code with a time of 90 minutes. The lowest valued of those, 22851, describes application of intervertebral biomechanical devices and has a work RVU of 6.70.

Reflecting a robust survey, and given the reduction in intraservice time for 93613, we **recommend the survey 25th-percentile work RVU of 5.23 with times of 0 minutes preservice, 90 minutes intraservice, and 0 minutes postservice**. This value is 25% lower than the current value proportionately captures the 25% reduction in time, as demonstrated by the constant IWPUT.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93613

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiac electrophysiology How often? Commonly

Specialty cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50,654 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2015 FFS utilization form RUC database.

Specialty cardiac electrophysiology Frequency 33654 Percentage 66.43 %

Specialty cardiology Frequency 15500 Percentage 30.59 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Imaging/procedure

BETOS Sub-classification Level II:
Heart inc. Cardiac Catheter

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93613

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SURVEY INTENSITY & COMPLEXITY ADDENDUM TABLE

Survey Code:	93613	**# of Respondents:**	47
Survey Code Descriptor:	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)		

Top Ref Code:	93609	**# of Respondents:**	26	**% of Respondents:**	55%
Top Ref Code Descriptor:	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)				

Survey Code Compared to Top Ref Code

Survey Code is:

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall Intensity and Complexity:	0%	0%	23%	54%	23%

		Less	Identical	More
Mental Effort and Judgment:	The number of possible diagnosis and/or number of management options that must be considered	0%	23%	77%
	The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	12%	31%	43%
	Urgency of medical decision making	4%	65%	31%
Technical Skill:		0%	23%	77%
Physical Effort:		11%	35%	54%
Psychological Stress:	The risk of significant complications, morbidity and/or mortality	15%	58%	27%
	Outcome depends on the skill and judgment of physician	0%	38%	62%
	Estimated risk of malpractice suite with poor outcome	12%	65%	23%

SS Rec Summary

ISSUE: EP 3D Mapping add-on

TAB: 24

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	93609	Intraventricular and/or intra-atria	26	0.055			4.99			90						90			
2nd REF	93655	Intracardiac catheter ablation of	13	0.083			7.50			90						90			
CURRENT	93613	Intracardiac electrophysiologic		0.058			6.99			120						120			
SVY	93613		47	0.078	2.25	5.23	7.00	8.00	15.00	90				30	48	90	120	400	
REC	93613			0.058			5.23			90						90			
MPC	57267	Insertion of mesh or other prost		0.108			4.88			45						45			
MPC	63048	Laminectomy, facetectomy and		0.077			3.47			45						45			
COMP	22851	Application of intervertebral bio		0.074			6.70			90						90			

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Tab Number

Intracardiac 3D Mapping
Issue

93613
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Mark H. Schoenfeld, MD

Signature

_Mark Schoenfeld, MD, FHRS
Printed Signature

_Heart Rhythm Society
Specialty Society

_12/13/2016
Date

_11, 19, 23, 24___
Tab Number

_Incompetent Vein, INR Monitoring, EP Device Monitoring, 3D Mapping____
Issue

___36470-71, 36475, 364X3-X6; 993X1-X2; 93293-95, 93297-98; 93613___
Code Range

Attestation Statement

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_____
Signature

_Richard Wright, MD_____
Printed Signature

___ACC_____
Specialty Society

___12/12/16_____
Date

CPT Code: 93613
Specialty Society('s) ACC, HRS

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: January 2017

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The reviewer panel utilized a consensus panel process to develop recommended inputs. **No clinical staff time, supplies, or equipment are recommended for this facility-based ZZZ code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Existing 93613.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: n/a

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: n/a

5. Please describe in detail the clinical activities of your staff: n/a

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

April 2019

Intracardiac Echocardiography

In January 2019, the Relativity Assessment Workgroup (RAW) reviewed services with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. CPT code 93662 was identified and the RUC recommended this service be surveyed for April 2019.

93662 ***Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 42 cardiologists and agreed on the following physician time component: 25 minutes of intra-service time.

The RUC reviewed the recommended survey 25th percentile work RVU of 2.53 and agreed that this value appropriately captures the amount of physician work involved. The recommended work value and time for this service reflects the change in technology from when it was last valued in 2000. Intracardiac echocardiography has become an essential tool for complex catheter ablation of many types of arrhythmias and it has also enabled operators to significantly reduce the use of fluoroscopy. Since this service was last valued, arrhythmia mapping systems have developed the ability to incorporate intracardiac echo images into 3-dimensional electroanatomical maps. This has improved the accuracy, safety and effectiveness of catheter ablation for a wide range of arrhythmias, most notably atrial fibrillation. To justify a work RVU of 2.53, the RUC compared the survey code to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and intra-service time of 20 minutes) and determined that the recommended work value for the survey code is supported by CPT code 34713 which has similar physician work and time. The RUC also compared the survey code to MPC code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and intra-service time of 30 minutes) and determined that the recommended work value is supported by MPC code 36476. The RUC agreed that both reference services bracket the survey code in both physician work and time, supporting the recommended work value for the survey code.

Additionally, survey respondents who selected coronary intravascular ultrasound (IVUS) code 92978 as the top key reference service (KRS), found the survey code to be more intense/complex overall. The RUC agreed that this comparison is reasonable, since the median survey time of 25 minutes for the survey code equals the 25-minute intra-service time for KRS code 92978, yet survey respondents estimated the survey code to be more work

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and takes significantly more mental effort and judgment than KRS code 92978, further supporting the recommended survey 25th percentile work RVU of 2.53 for the survey code. **The RUC recommends a work RVU of 2.53 for CPT code 93662.**

Practice Expense
These services are facility-only and have no direct practice inputs.

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	ZZZ	2.53

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93662 Tracking Number Original Specialty Recommended RVU: **2.53**
Presented Recommended RVU: **2.53**
Global Period: ZZZ Current Work RVU: **2.80** RUC Recommended RVU: **2.53**

CPT Descriptor: Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During the catheter ablation of a 57 year-old man with symptomatic paroxysmal atrial fibrillation, intracardiac ultrasound is used to guide the trans-septal puncture, evaluate left atrial and pulmonary vein anatomy, and monitor for intra-procedural complications.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Femoral venous access is obtained using fluoroscopic and or ultrasound guidance, avoiding the femoral artery. A 9 French or 10 French sheath is inserted into the vein. The intracardiac echo probe is advanced through the sheath, up the inferior vena cava to the right atrium again using fluoroscopic and intracardiac echo guidance, avoiding the venous branches and Eustachian ridge. The following structures are imaged for baseline anatomy: The fossa ovalis, aortic root, left atrium including the left atrial appendage, pulmonary veins, esophagus and the pericardial space to evaluate for document if a baseline effusion is present. Next, preparations for transseptal puncture are made by rotating and flexing the intracardiac echo catheter in 3 dimensions to identify the ideal location of the atrial septum for puncture. Under intracardiac echo guidance the transseptal needle is positioned in the appropriate portion of the septum. Intracardiac echo is used to confirm tenting of the septum by the needle at the desired location, and the puncture is then performed. Saline is flushed through the transseptal needle and intracardiac echo is used to confirm that the needle tip is in the left atrium by visualizing bubbles on intracardiac echo within the left atrium. A sheath is then advanced over the transseptal needle into the left atrium and the needle is withdrawn from the body. Throughout the remainder of the procedure intracardiac echo is used to confirm the position of the ablation catheter in the left atrium and it is used to monitor for complications including pericardial effusion and intracardiac thrombus. At the end of the procedure the catheter and sheaths are removed and hemostasis achieved using either manual pressure, vascular closure device or superficial stitches. Details of the procedure and then documented.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2019					
Presenter(s):	Mark Schoenfeld, MD; Richard Wright, MD; David Slotwiner, MD; Thad Waites, MD; Edward Tuohy, MD					
Specialty Society(ies):	HRS, ACC					
CPT Code:	93662					
Sample Size:	1000	**Resp N:**	42	**Response:** 4.2 %		
Description of Sample:	500 random HRS members; 500 random ACC members who designate EP in membership					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	43.00	**100.00**	120.00	250.00
Survey RVW:	1.80	2.53	**3.80**	5.15	8.25
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	20.00	**25.00**	35.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93662	**Recommended Physician Work RVU: 2.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92978	ZZZ	1.80	**RUC Time**

CPT Descriptor Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93613	ZZZ	5.23	**RUC Time**

CPT Descriptor Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	11,934

CPT Descriptor 1 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36476	ZZZ	2.65	**RUC Time**	9,561

CPT Descriptor 2 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
34713	ZZZ	2.50	**RUC Time**

CPT Descriptor Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 28.5 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 23.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93662	Top Key Reference CPT Code: 92978	2nd Key Reference CPT Code: **93613**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	25.00	25.00	90.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**25.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	17%	58%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	25%	67%
Physical effort required	0%	58%	42%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	30%	50%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	60%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	50%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

93662 is an add-on code used with several cardiac electrophysiology evaluation and/or ablation services. It can also be used with certain transcatheter structural valve procedures.

The RAW identified 93662 through its high-growth screen. A random survey of 1000 ACC and HRS members was executed with 42 completed surveys. The information obtained is used to develop the survey results in the SOR and the summary spreadsheet.

While we are not making a compelling evidence argument because we are recommending a reduction, we do wish to explain the ways this service is different from when it was valued in 2000. Intracardiac echo has become unessential to tool for complex catheter ablation of many types of arrhythmias. It has also enabled operators to significantly reduce the use of fluoroscopy. Over the past 15 years, arrhythmia mapping systems have developed the ability to incorporate intracardiac echo images into 3-dimensional electroanatomical maps. This has improved the accuracy, safety and effectiveness of catheter ablation for a wide range of arrhythmias, most notably atrial fibrillation.

The key reference service was selected by 12 respondents. Respondents who selected coronary intravascular ultrasound (IVUS) code 92978 as the key reference code found 93662 to be more intense/complex overall. This comparison is reasonable, since the median survey time of 25 minutes equals the 25-minute intraservice time for 92978, yet respondents estimated 93662 to be more work.

The second key reference service was selected by 10 respondents. Respondents who selected intracardiac 3D mapping code 93613 as the key reference code found 93662 to be identical or somewhat more intense/complex overall. However, comparison between 93662 and 93613 is challenging, as the latter has a much longer service time and higher work RVU than under discussion here.

Reflecting a valid survey, and given the reduction in intraservice time for 93662, we **recommend the survey 25th-percentile work RVU of 2.53 work RVUs with times of 0 minutes preservice, 25 minutes intraservice, and 0 minutes postservice**. This somewhat higher value reflects the higher intensity/complexity estimated by respondents who selected the KRS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 93662 may be billed with 92987, 93453, 93460-96462, 93532, 93580, 93581, 93620, 93621, 93622, 93653, 93654, or 93656.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93622

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiac electrophysiology How often? Commonly

Specialty cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 130000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Twice the utilization estimated below for Medicare

Specialty cardiac electrophysiology Frequency 71000 Percentage 54.61 %

Specialty cardiology Frequency 59000 Percentage 45.38 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 65,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. A continuation of recent growth trends of about 6,300 a year from 2015-2017 would lead to utilization of roughly 65,000 services in 2020.

Specialty cardiac electrophysiology Frequency 35500 Percentage 54.61 %

Specialty cardiology Frequency 29500 Percentage 45.38 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93662

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Intracardiac Echocardiography (ICE)

TAB: 23

						RVW						PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	92978	Endoluminal imaging of coronary	12	0.072			1.80			25						25								
2nd REF	93613	Intracardiac electrophysiologic	10	0.058			5.23			90						90								
CURRENT	93662	Intracardiac echocardiography d		0.045			2.80			70	5					55			10					
SVY	93662	Intracardiac echocardiography d	42	0.152	1.80	2.53	3.80	5.15	8.25	25				7	20	25	35	120		0	43	100	120	250
REC	93662	Intracardiac echocardiography d		0.101			2.53			25						25								
MPC	36227	Selective catheter placement, ex		0.139			2.09			15						15								
MPC	36476	Endovenous ablation therapy of		0.088			2.65			30						30								
COMP	34713	Percutaneous access and closur		0.125			2.50			20						20								

April 2, 2019

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 23 Practice Expense

Dear Dr. Manaker:

Tab 23 on the April 2019 RUC agenda addresses one add-on code for intracardiac echocardiography performed during other catheter procedures. This add-on service is provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 23.

Thank you for your consideration of this information as you prepare for the meeting. Please contact James Vavricek at jvavricek@acc.org if you have any questions.

Sincerely,

Richard Wright, MD
ACC RUC Advisor

Mark Schoenfeld, MD
HRS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2020

Electrophysiologic Evaluation - REVISED

In October 2019, the RUC identified this service via the high-volume growth screen for services with Medicare utilization of 10,000 or more and have increased by at least 100% from 2013 through 2018. In January 2020, the RUC recommended this service be surveyed for April 2020. The code was surveyed individually, as it is not part of a specific family, because it is an add-on service that can be used with several different procedures - base codes or other add-on codes, diagnostic as well as therapeutic.

93621 ***Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 53 cardiologists and cardiac electrophysiologists and determined that a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 1.75, 20 minutes intra-service and total time) would appropriately account for the physician work required to perform this service and falls below the survey 25th percentile.

The RUC discussed the decrease in intra-service time from 30 to 20 minutes and the accordant increase in intensity. Because the recommended work RVU is not an increase, a compelling evidence argument is not necessary. However, because of the change in calculated intensity that results from a decrease in intra-service time without an entirely commensurate decrease in work RVU, the specialty societies provided compelling evidence that there has been a change in technique that has changed physician work.

Since 2001, when this code was last surveyed, there have been several changes in technique that have contributed to an increase in the intensity and decrease in the total time of the procedure. In particular, the typical access technique has evolved to the femoral vein to insert the catheter, as opposed to the jugular or subclavian vein. Previously, a superior vena cava (SVC) approach via internal jugular (IJ) or subclavian vein access was the preferred route to access the coronary sinus. Anatomically, this provides an ideal angle from which to cannulate the coronary sinus which sits at the inferior posteroseptal region of the right atrium, just above the tricuspid valve. This angle makes it possible to use a simple fixed curve catheter and ensures that the catheter position will remain stable throughout the procedure. The downside of the superior approach is that it requires an additional access site (the internal jugular or subclavian vein) that would otherwise not be needed. This carries a small but real risk of pneumothorax and the IJ /

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subclavian access site can be uncomfortable for patients during and after the procedure. For these reasons, most electrophysiologists have evolved their practice and now use a femoral vein approach to deploy the coronary sinus catheter.

The femoral approach avoids the need to prep and drape an additional access site since the other sheaths and catheters for EP studies are also placed from a femoral approach. However, a separate and additional sheath needs to be inserted into the femoral vein for placement of the coronary sinus catheter. Due to the need for multiple sheaths in the same femoral vein access region, care must be taken during venous access to space the access sites sufficiently to avoid interference between the catheters. In addition, a femoral venous approach introduces anatomical challenges for cannulating the coronary sinus and does not provide the natural stability of the catheter achieved from a subclavian approach. The primary anatomical obstacles are the height of the eustachian ridge/inferior vena cava junction and the abrupt reverse angle (usually greater than 135 degrees) that the catheter must traverse once it passes above the eustachian ridge in order to enter to coronary sinus ostium. With the advent of manually deflectable catheters, electrophysiologists are usually (but not always) able to cannulate the coronary sinus from a femoral approach despite the anatomical challenges. However, because the anatomy (eustachian ridge/IVC junction) intrinsically puts pressure on the catheter in a direction that pulls it away from the coronary sinus, the catheter is much less stable than it would be from a superior approach. As a result, it is typical for the coronary sinus catheter to become dislodged multiple times in a single case requiring the operator to reposition the catheter each time.

The RUC agreed that the minutes reduced from the change in access site are at the lower end of the intensity spectrum for the service, which naturally leads to an increase in calculated intensity that is compounded by the increased intensity of making the turn at the IVC/eustachian ridge and multiple re-positionings of the catheter.

Another difference from 2001 is that this service is typically added on to EP-studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Medicare reported together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures. The survey add-on code is most often reported with ablation code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.75, 180 minutes intra-service time) and diagnostic code 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* (work RVU = 5.23, 90 minutes intra-service time). Specifically, the data shows that approximately 80% of 93621 is reported with CPT code 93653. The placement of a catheter for pacing/recording in the left atrium and coronary sinus is more complex/intense in an ablation versus a diagnostic procedure. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization.

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Moreover, the RUC notes that while it is uncommon for an add-on code to be more intense than the underlying service, it does occur, and it is common in the electrophysiology space. A relevant example is trans-septal puncture CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) that may be performed with SVT ablation CPT code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.75, 180 minutes intra-service and 239 minutes total time). The ablation procedure intensity is 0.075 while the puncture is more intense at 0.093. An intensity of 0.088 from the RVU recommendation for CPT code 93621 fits this model and is a reasonable intensity rank order.

The RUC compared CPT code 93621 to the second highest key reference service and MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25, 30 minutes intra-service and total time) and noted the intra-service time is 10 minutes less for the survey code and all the survey respondents that selected the second key reference code rated the survey code as more intense and complex overall relative to the reference code.

The RUC also identified CPT code 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80, 20 minutes intra-service time and 22 minutes total time) for comparison purposes and noted that the comparator code has the same amount of intra-service time and intensity as the survey code.

For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service time and 1 minute immediate post-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison codes appropriately bracket the survey code. The RUC further noted that there are 12 RUC reviewed ZZZ codes with 20 minutes intra-service time and work values between 1.40 and 2.00.

The RUC concluded that, given changes in intensity and total time for the procedure, CPT code 93621 should be valued based on a direct work RVU crosswalk to CPT code 36483 with 20 minutes intra-service time as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 93621.**

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Practice Expense
CPT code 93621 is provided exclusively in the facility setting; thus, no direct practice expense inputs are recommended.

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)	ZZZ	1.75

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93621 Tracking Number Original Specialty Recommended RVU: **2.10**
Presented Recommended RVU: **1.75**
Global Period: ZZZ Current Work RVU: **2.10** RUC Recommended RVU: **1.75**

CPT Descriptor: Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a separately reported cardiac electrophysiology procedure, a 37 year-old man with recurrent palpitations is indicated, for diagnostic purposes, for the recording of electrical activity from the left atrium and ventricle and to pace the left atrium.

[Note: This is an add-on code. Only consider the additional work for left atrial pacing and recording from coronary sinus or left atrium. Do not include any work that is included in base codes 93620, 93653 or 93654.]

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The patient is undergoing a separately reported cardiac electrophysiology procedure, and it is necessary to place a catheter in the coronary sinus to record left atrial activity. Femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2020					
Presenter(s):	Richard Wright, MD, Thad Waites, MD and Christpher Liu, MD, David Slotwiner, MD, Mark Schoenfeld, MD					
Specialty Society(ies):	American College of Cardiology; Heart & Rhythm Society					
CPT Code:	93621					
Sample Size:	1188	**Resp N:**	53			
Description of Sample:	random ACC electrophysiologist members and random HRS members					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	40.00	**75.00**	120.00	250.00
Survey RVW:	1.45	2.50	**3.20**	5.00	20.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	12.00	**20.00**	35.00	200.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93621	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93609	ZZZ	4.99	**RUC Time**

CPT Descriptor Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99292	ZZZ	2.25	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	12,831

CPT Descriptor 1 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	65,235

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36483	ZZZ	1.75	**RUC Time**

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 33.9 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 11.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 93621	Top Key Reference CPT Code: 93609	2nd Key Reference CPT Code: **99292**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	90.00	30.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**90.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	28%	28%	22%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	22%	28%	50%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	50%	39%
Physical effort required	22%	44%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	28%	39%	33%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	83%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	50%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	17%	83%
Physical effort required	0%	17%	83%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

At the April 2020 virtual RUC meeting, the RUC recommended a value of 1.44, a crosswalk to CPT code 37253. The societies appealed that outcome after feeling limited by the virtual format, unable to adequately consult with one another or facilitate in the typical manner. That appeal was granted, and this SOR is a re-presentation of data from the April survey with reconfigured and enhanced recommendations the societies believe provide a satisfactory path forward.

In October 2019, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2013 through 2018, including CPT 93621 electrophysiologic evaluation.

For the April 2020 meeting, HRS and ACC randomly surveyed electrophysiologists, as designated by membership rolls. The survey was completed by physicians who have experience with the service. The key reference code is 93609 for intraventricular and/or intra-atrial mapping of tachycardia with catheter manipulation. It was selected by 33.9% of respondents. Nearly a third of these respondents indicate 93621 was virtually identical. The second reference code was 99292 for critical care evaluation. It was selected by 11.3% of respondents. All of these respondents indicated that 93621 was more intense/complex overall.

Since 2001, when this code was last surveyed, there have been a number of changes in technique that have contributed to change in intensity and total time of the procedure. In particular the typical access technique has evolved to the femoral vein to insert the catheter (as included in the updated description of service above), as opposed to the jugular or subclavian vein (as currently presented from the 2001 survey in the RUC database).

Compelling Evidence-Type Explanation for RVU Recommendation

Because the recommended work RVU is not an increase, a compelling evidence argument is not necessary. However, because of the change in calculated intensity that results from a decrease in intraservice time without an entirely commensurate decrease in work RVU, the societies make a compelling evidence-type presentation here. Specifically, there has been a change in technique that has changed physician work.

The technique used for coronary sinus catheter placement has evolved. Previously, a superior vena cava (SVC) approach via internal jugular (IJ) or subclavian vein access was the preferred route to access the coronary sinus. Anatomically, this provides an ideal angle from which to cannulate the coronary sinus which sits at the inferior posteroseptal region of the right atrium, just above the tricuspid valve. This angle makes it possible to use a simple fixed curve catheter and ensures that the catheter position will remain stable throughout the procedure. The downside of the superior approach is that it requires an additional access site (the internal jugular or subclavian vein) that would otherwise not be needed. This carries a small but real risk of pneumothorax and the IJ / subclavian access site can be uncomfortable for patients during and after the procedure. For these reasons, most electrophysiologists have evolved their practice and now use a femoral vein approach to deploy the coronary sinus catheter.

The femoral approach avoids the need to prep and drape an additional access site since the other sheaths and catheters for EP studies are also placed from a femoral approach. However, a separate and additional sheath does need to be inserted into the femoral vein for placement of the coronary sinus catheter. Due to the need for multiple sheaths in the same femoral vein access region, care must be taken during venous access to space the access sites sufficiently to avoid interference between the catheters. In addition, a femoral venous approach introduces anatomical challenges for cannulating the coronary sinus and does not provide the natural stability of the catheter achieved from a subclavian approach. The primary anatomical obstacles are the height of the eustachian ridge/inferior vena cava junction and the abrupt reverse angle (usually greater than 135 degrees) that the catheter must traverse once it passes above the eustachian ridge in order to enter to coronary sinus ostium. With the advent of manually deflectable catheters, electrophysiologists are usually (but not always) able to cannulate the coronary sinus from a femoral approach despite the anatomical challenges. However, because the anatomy (eustachian ridge/IVC junction) intrinsically puts pressure on the catheter in a direction that pulls it away from the coronary sinus, the catheter is much less stable than it would be from a superior approach. As a result, it is typical for the coronary sinus catheter to become dislodged multiple times in a single case requiring the operator to reposition the catheter each time.

We believe the minutes reduced from the change in access site are at the lower end of the intensity spectrum for the service, which naturally leads to an increase in calculated intensity that is compounded by the increased intensity of making the turn at the IVC/eustachian ridge and multiple re-positionings of the catheter.

Another difference from 2001 to now is that this service is typically added on to EP-studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Billed together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures, specifically the data shows that roughly 78% of 93621 is billed with 93653. This is another difference from the 2001 valuation. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization.

For comparison purposes, the societies identified RVW comparator code 37252 for intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention. This code has the same amount of intraservice time, 20 minutes and, correctly, a slightly lower IWPUT of 0.088 than results from our recommendation. The societies also identified two other comparator codes that bracket the recommendation: 36483 for endovenous ablation therapy at 1.75 RVW with a slightly higher intensity than the recommendation at 0.088. This code reflects a mostly 'technical' procedure. The second code, 36227 for selective catheter placement has an RVW of 2.09 and a higher intensity of 0.1393 IWPUT.

Finally, revisiting a topic that arose during the first presentation of this code, while it is uncommon for an add-on code to be more intense than the underlying service, it does occur and it is common in the electrophysiology space. A relevant example is trans-septal puncture (93462) that may be performed with SVT ablation (93653). The ablation procedure IWPUT is 0.075 while the puncture is more intense at 0.093. An IWPUT of 0.088 from the RVU recommended below fits this model, and is a reasonable IWPUT rank order to the expert panel.

Recommendation

Therefore, for code 93621 the societies **recommend a crosswalk to the RVW of 1.75 from code 36483 with 0 minutes preservice time, 20 minutes intraservice time from the survey median, and 0 minutes postservice time**.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93621

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ACC How often? Commonly

Specialty HRS How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 59784
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on double the Medicare data estimation reported in 2018.

Specialty Cardiac Electrophysiology Frequency 48000 Percentage 80.28 %

Specialty Cardiology Frequency 11794 Percentage 19.72 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 29,892 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Fee for service utilization from RUC database from 2018 for 93621.

Specialty Cardiac Electrophysiology Frequency 24000 Percentage 80.28 %

Specialty Cardiology Frequency 5892 Percentage 19.71 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93621

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Eletrophysiological services

TAB: 21

Source	CPT	Global	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	93609	ZZZ	Intraventricular and/or intra-atrial mapping of tachycardia	18	0.055			4.99			90	0	0	0			90			0					
2nd REF	99292	ZZZ	Critical care, evaluation and management of the critically ill	6	0.075			2.25			30	0	0	0			30			0					
CURRENT	93621	ZZZ	Comprehensive electrophysiologic evaluation		0.070			2.10			30						30			0					
SVY	93621	ZZZ	Comprehensive electrophysiologic evaluation	53	0.160	1.45	2.50	3.20	5.00	20.00	20	0	0	0	5	12	20	35	200	0	0	40	75	120	250
REC	93621	ZZZ	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple		0.088			1.75			20	0	0	0			20			0					
COMP	37252	ZZZ	Intravascular ultrasound (noncoronary vessel) during		0.088			1.80			22	1	0	0			20			1					
COMP	20931	ZZZ	Allograft, structural, for spine surgery only (List separately in		0.091			1.81			20	0	0	0			20			0					
COMP	15151	ZZZ	Tissue cultured skin autograft, trunk, arms, legs; additional 1		0.100			2.00			20	0	0	0			20			0					
COMP XWALK	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity,		0.088			1.75			20	0	0	0			20			0					
MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during		0.071			1.44			21	0	0	0			20			1					
MPC	36227	ZZZ	Selective catheter placement, external carotid artery,		0.1393			2.09			15	0	0	0			15			0					

August 25, 2020

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 21 Practice Expense

Dear Dr. Manaker:

Tab 21 on the October 2020 RUC agenda addresses one add-on code for electrophysiologic services. This add-on service is provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 21.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,

Richard Wright, MD
ACC RUC Advisor

Mark Schoenfeld, MD
HRS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Endoscopic Bariatric Device Procedures – Tab 8

In February 2021, the CPT Editorial Panel approved the addition of two codes to report esophagogastroduodenoscopy, flexible, transoral with deployment and removal of intragastric bariatric balloon. CPT code 43235 was identified as being part of the same family of services.

43235 ***Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)***
The RUC reviewed the survey results from 54 gastrointestinal and endoscopic surgeons and bariatric surgeons and determined that maintaining the current work RVU of 2.09, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends 14 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 15 minutes intra-service time and 12 minutes immediate post-service time. Pre-service time package 1 (Straightforward Patient/Straightforward Procedure (No anesthesia care)) and post-service time package 8A (IV Sedation/ Straightforward Procedure) are recommended as adjusted. CPT code 43235 is typically performed with either moderate sedation or anesthesia. In 2017, when moderate sedation was removed from GI endoscopy codes and other codes where moderate sedation was considered inherent to the procedure, it became historical precedent that moderate sedation is separately reported. Therefore, moderate sedation CPT codes 99152 and 99153 or 00731 would be reported typically on the same date with 43235 (43290 or 43291). No multiple procedures reduction policies apply.

To justify a work RVU of 2.09, the RUC compared CPT code 43235 to the top key reference service code 43202 *Esophagoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU = 1.72, 15 minutes intra-service time 47 minutes total time) and noted that the reference service has identical intra-service time but is less intense than the survey code and appropriately valued lower. The RUC also compared the survey code to the second key reference code 43216 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU = 2.30, 22 minutes intra-service time and 55 minutes total time) and noted that the reference service has more intra-service and total time and is appropriately valued higher than 43235.

For additional support, the RUC compared CPT code 43235 to MPC codes 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 15 minutes intra-service time and 49 minutes total time) and 64479 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level* (work RVU = 2.29, 15 minutes intra-service time and 49 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that the value of CPT code 43235 should be maintained at 2.09 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 2.09 for CPT code 43235.**

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43290 ***Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon***
The RUC reviewed the survey results from 51 gastrointestinal and endoscopic surgeons and bariatric surgeons and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy;* (work RVU = 3.11, 30 minutes intra-service time and 83 minutes total time), which falls below the survey 25th percentile and has identical intra-service time, appropriately accounts for the physician work involved in this service. The RUC believed that the survey 25th percentile work RVU was too high in comparison to other services and agreed with the crosswalk to 31256. Alternative crosswalks were considered; however, the nasal endoscopy code, 31256, was deemed most clinically comparable and the value fits within the context of the EGD family. The RUC noted that in a comparison of recently RUC-reviewed 000-day global codes with similar intra-service and total times, the crosswalk value of 3.11 falls in the middle range in terms of work RVUs.

The RUC recommends 18 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 30 minutes intra-service time and 20 minutes immediate post-service time, 76 minutes total time. Pre-service time package 2 (Difficult Patient/Straightforward Procedure (No anesthesia care)) and post-service time package 8A are recommended as adjusted. The typical patient is considered difficult based on an elevated BMI of 30-40. The RUC noted that the requested pre-service physician time components differ slightly from the package and specifically align with the traditional GI endoscopy pre-times: 18 minutes evaluation time, 3 minutes positioning time, and 5 minutes scrub/dress/wait time.

To justify the crosswalk value of 3.11 work RVUs, the RUC compared CPT code 43290 to key reference code 43226 *Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire* (work RVU = 2.24, 25 minutes intra-service time and 57 minutes total time) and noted that the reference service has less intra-service and total time and is a less complex procedure than the survey code and appropriately valued lower.

For additional support, the RUC compared CPT code 43290 to MPC codes 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU = 2.75, 30 minutes intra-service time and 76 minutes total time) and 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46, 30 minutes intra-service time and 73 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that CPT code 43290 should be valued based on a direct work RVU crosswalk to CPT code 31256 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 3.11 for CPT code 43290.**

43291 ***Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)***
The RUC reviewed the survey results from 51 gastrointestinal and endoscopic surgeons and bariatric surgeons and determined that the survey 25th percentile work RVU of 2.80 appropriately accounts for the physician work involved in this service. The RUC recommends 18 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 30 minutes intra-service time and 15 minutes immediate post-service time. The RUC noted that the requested pre-service physician time components specifically align with the rest of

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the gastrointestinal endoscopy pre-times: 18 minutes evaluation time, 3 minutes positioning time, and 5 minutes scrub/dress/wait time. Pre-service time package 2 and post-service time package 9A (General Anesthesia or Complex Regional Block/ Straightforward Procedure) are recommended as adjusted. The RUC noted that typically the patient is intubated and concurred that post-time package 9A, as adjusted per the survey, is most appropriate.

To justify a work RVU of 2.80, the RUC compared CPT code 43291 to the top key reference service code 43215 *Esophagoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU = 2.44, 20 minutes intra-service time and 53 minutes total time) and noted that the reference service has ten minutes less intra-service time than the survey code and is appropriately valued lower.

For additional support, the RUC compared CPT code 43291 to MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.53, 30 minutes intra-service time and 61 minutes total time) and 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46, 30 minutes intra-service time and 73 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that CPT code 43291 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.80 for CPT code 43291.**

Practice Expense
For CPT code 43290, the Practice Expense Subcommittee adjusted five minutes of clinical staff time between CA005 *Complete pre-procedure phone calls and prescription* (3 minutes) and CA035 *Complete pre-procedure phone calls and prescription* (2 minutes). The Subcommittee also verified that the new supply item, *Intragastric Balloon System,* is not reusable. When it is removed, the balloon is punctured so it cannot be reused in another patient. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 43290 and 43291 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Digestive System** **Esophagus** **Endoscopy** **Esophagoscopy**				
43197		*Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (Do not report 43197 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43198, 43290, 43200-43232, 43235-43259, 43266, 43270, *43497*, 92511, *0652T, 0653T, 0654T)* *(Do not report 43197 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)* *(For transoral esophagoscopy, see 43191, 43200)*		
43198		*with biopsy, single or multiple* (Do not report 43198 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43197, 43290, 43200-43232, 43235-43259, 43266, 43270, 92511, *0652T, 0653T, 0654T)* *(Do not report 43198 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)* *(For transoral esophagoscopy with biopsy, see 43193, 43202)*		
Esophagogastroduodenoscopy				
(f)43235	B1	*Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (Do not report 43235 in conjunction with 43197, 43198, 43290, 43210, 43236-43259, 43266, 43270, *43497,* 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379)	000	2.09 (No change)

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43241		*with insertion of intraluminal tube or catheter* (Do not report 43241 in conjunction with 43197, 43198, 43290, 43212, 43235, 43266, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379)		
43247		*with removal of foreign body(s)* (Do not report 43247 in conjunction with 43197, 43198, 43290, 43291, 43235, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379) *(If fluoroscopic guidance is performed, use 76000)*		
●43290	B2	with deployment of intragastric bariatric balloon (Do not report 43290 in conjunction with 43197, 43198, 43235, 43241, 43247)	000	3.11
●43291	B3	with removal of intragastric bariatric balloon(s) (Do not report 43291 in conjunction with 43197, 43198, 43235, 43247)	000	2.80
43248		*with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire* *(Do not report 43248 in conjunction with 43197, 43198, 43235, 43266, 43270, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379)* *(If fluoroscopic guidance is performed, use 74360)*		

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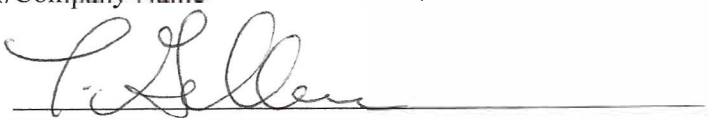
AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

43290, 43291
CPT® Codes

Apollo Endosurgery
Vendor/Company Name

By: 

Tiffanie Gilbreth
Printed Signature

VP Clinical & Medical Affairs
Title

February 11, 2021
Date

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43235 Tracking Number B1 Original Specialty Recommended RVU: **2.09**
Presented Recommended RVU: **2.09**
Global Period: 000 Current Work RVU: **2.09** RUC Recommended RVU: **2.09**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old patient with dyspepsia and weight loss refractory to pharmacological therapy is referred for diagnostic esophagogastroduodenoscopy (EGD) and collection of specimens by brushings.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient's gastrointestinal symptoms. Review the need for pre-procedure antibiotics or contrast allergy prophylaxis. Review patient's allergies and medications, specifically noting usage of antiplatelet or anticoagulation medications. Review patient's laboratory studies as they relate to coagulation status and platelet count. Review patient's X-rays and other diagnostic tests. Review the risks and benefits of the procedure with the patient. Obtain informed consent for the procedure. Verify all endoscopic equipment is available and operational and make appropriate computer entries as necessary. Position patient on the examination table. Position endoscopic equipment to provide access for the procedure. Perform a time out. Apply topical anesthesia to the throat. Place a bite-block in patient's mouth.

Description of Intra-Service Work: Assess level of sedation prior to inserting the endoscope. Insert a standard flexible upper endoscope through the mouth into the oropharynx and advance through the esophagus into the proximal stomach. Insufflate the stomach with air after suctioning liquid contents. Perform an examination of the entire stomach in the forward and retroflexed positions. Advance the endoscope through the pylorus into the duodenal bulb. Inspect the duodenum circumferentially after air insufflation. Slowly withdraw the endoscope and reinspect the stomach and duodenum. After suctioning air to deflate the stomach, withdraw the endoscope into the esophagus, allowing measurement of the squamocolumnar (SC) and gastroesophageal (GE) junction from the incisors. Assess for presence of a hiatal hernia and examine the esophageal mucosa. When indicated, obtain brushings or washings of suspicious abnormalities. Obtain photodocumentation of appropriate normal landmarks and abnormalities. Withdraw the endoscope at the conclusion of the procedure.

Description of Post-Service Work: Assess patient's condition including post-procedure vital signs. Complete post-procedure orders. Complete cytology forms as necessary. Complete post-procedure specimen verification and documentation and reporting for quality purposes. Review and label photographs. Order and review post-procedure radiographs. Generate a procedure report and forward to referral source and other appropriate parties. Enter data into the procedure registry. Assess patient for suitability to discharge from the recovery suite relative to established discharge criteria. When patient is stable for discharge, review findings and recommendations with the patient and pertinent others. Provide orders for necessary prescriptions, follow-up tests, and appointments to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021		
Presenter(s):	R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)		
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of American Gastrointestinal and Endoscopic Surgeons		
CPT Code:	43235		
Sample Size:	2328	**Resp N:**	54
Description of Sample:	The ACG, AGA and ASGE surveyed a random sample of 1,000 members; with email bouncebacks, 974 surveys were successfully delivered. SAGES surveyed the 160 members of their metabolic and bariatric surgeon and advanced endoscopy members. ASGE surveyed the 260 members of its Association for Bariatric Endoscopy (ABE). We also surveyed the 992 physician list provided by industry; with email bouncebacks, 934 surveys were successfully delivered. 974 (random sample) + 160 (SAGES metabolic and bariatric surgeon and advanced endoscopy group) + 260 (ASGE ABE) + 934 (Industry list) = 2,328		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**135.00**	300.00	1000.00
Survey RVW:	1.50	2.10	**2.25**	2.50	4.00
Pre-Service Evaluation Time:			**23.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	7.00	11.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**13.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	43235	**Recommended Physician Work RVU: 2.09**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**13.00**	**1.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

8A IV Sedation/Simple Procedure

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**12.00**	**25.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43202	000	1.72	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with biopsy, single or multiple

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43216	000	2.30	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 1 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	44,367

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 50.9 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 9.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 43235	**Top Key Reference CPT Code:** 43202	**2nd Key Reference CPT Code:** **43216**
Median Pre-Service Time	22.00	22.00	23.00
Median Intra-Service Time	15.00	15.00	22.00
Median Immediate Post-service Time	12.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**49.00**	**47.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	50%	46%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	54%	38%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	54%	42%
Physical effort required	4%	62%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	73%	23%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	80%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	20%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	40%	40%	20%
Physical effort required	20%	60%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	60%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal at the February 2021 CPT Editorial Panel meeting to add category I CPT codes for endoscopic bariatric device procedures to the esophagogastroduodenoscopy (EGD) code family. CPT code 43235 is the base code for the EGD family and was surveyed with the new endoscopic bariatric device procedures, 43290 and 43291.

43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

43290 with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance

43291 with removal of intragastric bariatric balloon(s)

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43290 and 43291 together using both a random sample of the GI societies' memberships and a targeted survey of the ASGE Association for Bariatric Endoscopy (ABE), a vendor list from Apollo Endosurgery Inc. and SAGES' metabolic and bariatric surgeon and advanced endoscopy members. The Research Subcommittee also provided input on our reference service list.

Our multi-specialty consensus panel reviewed the survey data for codes 43235, 43290 and 43291, comparing the data and work RVUs (wRVUs) to the current data for similar 000-day global codes that were recently approved by the RUC.

43235 – Discussion and Recommendation

Code 43235 is an existing code that was last reviewed by the RUC in January 2013. The ACG, AGA, ASGE and SAGES conducted a survey for the April 2021 RUC meeting and received 54 responses: 22 from the targeted survey of the industry list, 7 from SAGES' metabolic and bariatric surgeon and advanced endoscopy members, 15 from the ASGE ABE (labeled "GI-targeted" in the Survey Summary Spreadsheet) and 10 from the random sample of the GI societies' membership.

We recommend the existing **wRVU of 2.09**. This value is less than the 25th percentile of the combined survey data (2.10 wRVU).

Pre-time Package 1 (*Straightforward Patient/Straightforward Procedure (No anesthesia care)*) is appropriate with 14 minutes of evaluation time, reflecting the current pre-service time, 3 minutes positioning time and 5 minutes scrub, dress, wait time.

Pre-service evaluation time: 14 minutes
Pre-service positioning time: 3 minutes
Pre-service scrub, dress, wait time: 5 minutes

Post-time Package 8A (*IV Sedation/ Straightforward Procedure*) is appropriate with 12 minutes of immediate post-service time, reflecting the survey median.

Intra-service time of 15 minutes is appropriate, reflecting the survey median.

Key Reference Services

Two reference services were selected more often than others: 43202 and 43216. However, code 43202 (*Esophagoscopy, flexible, transoral; with biopsy, single or multiple*) was selected most often (26/54).

Comparison to recently RUC-reviewed 0-day global codes with 15 minutes intra-service time and similar total time:

CPT Code: 43235

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre S/D/W Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
45335	Sigmoidoscopy, flexible; with dire	000	1.04	1b	14	3.0	5.0	15	10	47	RUC	2013-10	GASTROENTEROLOGY	0.026		3141
50431	Injection procedure for antegrad	000	1.10	2a	18	1.0	6.0	15	15	55	RUC	2015-01	DIAGNOSTIC RADIOLOGY	0.019		8818
45331	Sigmoidoscopy, flexible; with bio	000	1.14	1a	13	3.0	5.0	15	10	46	RUC	2013-10	GASTROENTEROLOGY	0.035		36318
44385	Endoscopic evaluation of small ir	000	1.20	1b	14	3.0	5.0	15	10	47	RUC	2013-10	COLORECTAL SURGERY (PROCT)	0.037		1312
43450	Dilation of esophagus, by unguid	000	1.28	1b	14	3.0	5.0	15	14	51	RUC	2012-10	GASTROENTEROLOGY	0.036	Yes	71670
47531	Injection procedure for cholangic	000	1.30	2A	18	3.0	6.0	15	12	54	RUC	2015-10	DIAGNOSTIC RADIOLOGY	0.034		8621
51710	Change of cystostomy tube; com	000	1.35	5	7	5.0		15	15	42	RUC-CMS	2010-10	UROLOGY	0.050	Yes	17483
64446	Injection(s), anesthetic agent(s) a	000	1.36	1	13	1.0	5.0	15	6	40	RUC	2018-10	ANESTHESIOLOGY	0.058		5880
32561	Instillation(s), via chest tube/cath	000	1.39	1a	13	1.0	6.0	15	10	45	RUC	2009-04	PULMONARY DISEASE	0.054		2664
43200	Esophagoscopy, flexible, transora	000	1.42	1b	14	3.0	5.0	15	10	47	RUC	2012-10	OTOLARYNGOLOGY	0.052		5390
51703	Insertion of temporary indwelling	000	1.47	6A	10	5.0	5.0	15	10	45	RUC	2016-01	UROLOGY	0.058		54647
64487	Transversus abdominis plane (TA	000	1.48	1a	5	5.0	5.0	15	10	40	RUC	2014-04	ANESTHESIOLOGY	0.066		392
33286	Removal, subcutaneous cardiac r	000	1.50	1	13	1.0	6.0	15	10	45	RUC	2017-04	CARDIAC ELECTROPHYSIOLOGY	0.061		16939
15271	Application of skin substitute gra	000	1.50	1a	13	1.0	6.0	15	10	45	RUC	2011-04	PODIATRY	0.061		111779
64493	Injection(s), diagnostic or therap	000	1.52	5	7	5.0	5.0	15	10	42	RUC	2009-04	PAIN MANAGEMENT	0.066		901171
43197	Esophagoscopy, flexible, transna	000	1.52	6	17	1.0	5.0	15	10	48	RUC-CMS	2012-10	OTOLARYNGOLOGY	0.057		1136
64451	Injection(s), anesthetic agent(s) a	000	1.52		17	1.0	5.0	15	7	45	RUC	2019-01		0.061		
62284	Injection procedure for myelogra	000	1.54	1a	13	5.0	6.0	15	10	49	RUC	2014-04	DIAGNOSTIC RADIOLOGY	0.058		16213
45333	Sigmoidoscopy, flexible; with ren	000	1.55	1b	14	3.0	5.0	15	10	47	RUC	2013-10	GASTROENTEROLOGY	0.060		734
36516	Therapeutic apheresis; with extra	000	1.56	6	25			15	10	50	RUC	2017-01	ENDOCRINOLOGY	0.052		1069
62272	Spinal puncture, therapeutic, for	000	1.58	1	13	4.0	5.0	15	15	52	RUC	2019-01	NEUROSURGERY	0.055		6301
64488	Transversus abdominis plane (TA	000	1.60	1a	5	5.0	5.0	15	10	40	RUC	2014-04	ANESTHESIOLOGY	0.074		54919
36573	Insertion of peripherally inserted	000	1.70	1	10	3.0	6.0	15	6	40	RUC	2018-01	DIAGNOSTIC RADIOLOGY	0.082		88728
19285	Placement of breast localization (	000	1.70	1a	13	1.0	6.0	15	15	50	RUC	2013-04	DIAGNOSTIC RADIOLOGY	0.067		25714
10035	Placement of soft tissue localizat	000	1.70	1a	13	2.0	5.0	15	10	45	RUC	2015-04	DIAGNOSTIC RADIOLOGY	0.073		7485
43201	Esophagoscopy, flexible, transora	000	1.72	1b	14	3.0	5.0	15	10	47	RUC	2012-10	GASTROENTEROLOGY	0.072		220
43202	Esophagoscopy, flexible, transora	000	1.72	1b	14	3.0	5.0	15	10	47	RUC	2012-10	GASTROENTEROLOGY	0.072		2578
64461	Paravertebral block (PVB) (paras	000	1.75	1a	13	1.0	5.0	15	10	44	RUC	2015-04	ANESTHESIOLOGY	0.078		4096
36556	Insertion of non-tunneled centra	000	1.75	1a	12	3.0	5.0	15	5	40	RUC	2016-10	ANESTHESIOLOGY	0.084	Yes	409595
62326	Injection(s), including indwelling	000	1.78	1A	10	3.0	5.0	15	10	43	RUC	2015-10	ANESTHESIOLOGY	0.082		4644
62323	Injection(s), of diagnostic or ther	000	1.80	1A	10	5.0	5.0	15	10	45	RUC	2015-10	ANESTHESIOLOGY	0.080		699990
62320	Injection(s), of diagnostic or ther	000	1.80	1A	10	3.0	5.0	15	10	43	RUC	2015-10	ANESTHESIOLOGY	0.083		5631
64490	Injection(s), diagnostic or therap	000	1.82	5	7	5.0	5.0	15	10	42	RUC	2009-04	PAIN MANAGEMENT	0.086		265103
15275	Application of skin substitute gra	000	1.83	1a	13	1.0	6.0	15	10	45	RUC	2011-04	PODIATRY	0.083		122551
47537	Removal of biliary drainage cathe	000	1.84	2A	18	3.0	6.0	15	10	52	RUC	2015-10	DIAGNOSTIC RADIOLOGY	0.073		1737
62324	Injection(s), including indwelling	000	1.89	1A	10	3.0	5.0	15	10	43	RUC	2015-10	ANESTHESIOLOGY	0.089		19559
64483	Injection(s), anesthetic agent(s) a	000	1.90	1a	13	5.0	6.0	15	10	49	RUC	2009-10	PHYSICAL MEDICINE & REHAB	0.082	Yes	1044547
62327	Injection(s), including indwelling	000	1.90	1A	10	5.0	5.0	15	10	45	RUC	2015-10	PAIN MANAGEMENT	0.087		1995
11983	Removal with reinsertion, non-bi	000	1.91	6	15	1.0	4.0	15	5	40	RUC	2018-10	ORTHOPEDIC SURGERY	0.094		2345
36555	Insertion of non-tunneled centra	000	1.93	1a	15	3.0	5.0	15	10	48	RUC	2016-10	ANESTHESIOLOGY	0.084		26
62321	Injection(s), of diagnostic or ther	000	1.95	1A	10	5.0	5.0	15	10	45	RUC	2015-10	ANESTHESIOLOGY	0.090		217240
92960	Cardioversion, elective, electrical	000	2.00	1b	10	1.0	5.0	15	15	46	RUC	2010-10	CARDIOLOGY	0.092		201622
45338	Sigmoidoscopy, flexible; with ren	000	2.05	2b	15	3.0	5.0	15	10	48	RUC	2013-10	GASTROENTEROLOGY	0.092		5383
69801	Labyrinthotomy, with perfusion c	000	2.06	6	12	1.0	5.0	15	10	43	RUC	2010-04	OTOLARYNGOLOGY	0.100		24321
43235	Esophagogastroduodenoscopy, fl	000	2.09	1b	14	3.0	5.0	15	12	49	RUC	2013-01	GASTROENTEROLOGY	0.093		323621
31577	Laryngoscopy, flexible; with remo	000	2.19	6A	13	1.0	9.0	15	10	48	RUC	2015-10	OTOLARYNGOLOGY	0.105		80
62325	Injection(s), including indwelling	000	2.20	1A	10	5.0	5.0	15	10	45	RUC	2015-10	ANESTHESIOLOGY	0.107		1225
64479	Injection(s), anesthetic agent(s) a	000	2.29	1a	13	5.0	6.0	15	10	49	RUC	2009-10	PHYSICAL MEDICINE & REHAB	0.108	Yes	44367
31574	Laryngoscopy, flexible; with injec	000	2.43	6A	20	1.0	9.0	15	10	55	RUC	2015-10	OTOLARYNGOLOGY	0.111		4008
31573	Laryngoscopy, flexible; with thera	000	2.43	6A	17	1.0	9.0	15	10	52	RUC	2015-10	OTOLARYNGOLOGY	0.115		2503
31578	Laryngoscopy, flexible; with remo	000	2.43	6A	16	1.0	9.0	15	10	51	RUC	2015-10	OTOLARYNGOLOGY	0.117		59
27250	Closed treatment of hip dislocati	000	3.82		15	5.0	5.0	15	13	53	RUC	2008-02	EMERGENCY MEDICINE	0.203		3180

The table below pertains to the next section on SERVICES REPORTED WITH MULTIPLE CPT CODES:

EGD (43235) with moderate sedation provided by same physician

Provider	CPT	Description	Global	wRVU	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X22	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000	2.80	26	30	15	No
GI or endoscopic surgeon	99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	XXX	0.25	0	12	0	No
GI or endoscopic surgeon	99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	XXX	0.00	0	0	0	No

EGD (43235) with anesthesia

Provider	CPT	Description	Global	wRVU	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X22	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000	2.80	26	30	15	No
Anesthesia professional	00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	XXX	5.00	19	25	10	No

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 43235 is typically performed with either moderate sedation or anesthesia. When moderate sedation was removed from GI endoscopy codes and other codes where moderate sedation was considered inherent to the procedure, it became historical precedent that moderate sedation is separately reported. Codes 99152 and 99153 or 00731 would be reported typically on the same date with 43235. No multiple procedures reduction policies apply. See section above for a table including CPT codes, global period, work RVUs, pre, intra and post-time and performing physician.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43235

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty General Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 970863
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 CMS volume is 323,621. National volume is estimated to be three times Medicare. 323,621 x 3 = 970,863

Specialty Gastroenterology Frequency 813584 Percentage 83.80 %

Specialty General Surgery Frequency 94174 Percentage 9.70 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 323,621 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 CMS volume = 323,621

Specialty Gastroenterology Frequency 271195 Percentage 83.80 %

Specialty General Surgery Frequency 31392 Percentage 9.70 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Endoscopy

BETOS Sub-classification Level II:
Upper Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number
43235

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43290 Tracking Number B2 Original Specialty Recommended RVU: **3.40**
Presented Recommended RVU: **3.11**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **3.11**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female with a body mass index (BMI) of 33 who has failed to respond to dietary and pharmacologic interventions for weight loss undergoes endoscopically guided insertion of a gastric balloon.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient's obesity criteria and associated comorbid conditions. Review patient's prior surgical history with specific attention to prior abdominal surgery. Review patient's allergies and medications, specifically noting usage of antiplatelet or anticoagulation medications. Discuss case planning with anesthesia team. Review patient's laboratory studies as they relate to coagulation status and platelet count. Review patient's other diagnostic tests. Review the risks and benefits of the procedure. Obtain informed consent. Verify all endoscopic equipment is available and operational and make appropriate computer entries as necessary. Position patient on the examination table. Position endoscopic equipment to provide access for the procedure. Perform a time out. Place a bite-block in patient's mouth.

Description of Intra-Service Work: Assess level of sedation prior to inserting the endoscope. Insert a standard flexible upper endoscope through the mouth into the oropharynx and advance through the esophagus into the proximal stomach. Insufflate the stomach with air after suctioning liquid contents. Perform an examination of the entire stomach in the forward and retroflexed positions. Advance the endoscope through the pylorus into the duodenal bulb. Inspect the duodenum circumferentially after air insufflation. Slowly withdraw the endoscope and reinspect the stomach and duodenum. After suctioning air to deflate the stomach, withdraw the endoscope into the esophagus, allowing measurement of the squamocolumnar (SC) and gastroesophageal (GE) junction from the incisors. Assess for presence of a hiatal hernia and examine the esophageal mucosa. When indicated, obtain brushings or washings of suspicious abnormalities. Obtain photodocumentation of appropriate normal landmarks and abnormalities. The endoscope is withdrawn. The intragastric balloon catheter is then advanced into the stomach based on the markings on the catheter and the prior noted location of the SCJ. The scope is reinserted to confirm and adjust the position of the collapsed intragastric balloon into the body of the stomach. The endoscope is then withdrawn to the level of GE junction at which point the stiffening wire is removed from the delivery catheter. The balloon is slowly inflated using saline with or without methylene blue dye. After the intragastric balloon is inflated to the desired volume, the catheter is disengaged from the intragastric balloon. The balloon and stomach are inspected to make sure there is no evidence of fluid leakage. The catheter is then completely removed. Photodocumentation is obtained confirming intragastric balloon placement in the stomach. The endoscope is then removed and procedure is complete.

Description of Post-Service Work: Assess patient's condition including post-procedure vital signs. Complete post-procedure orders. Review and label photographs. Generate a procedure report and forward to referral source and other appropriate parties. Assess patient for suitability to discharge from the recovery suite relative to established discharge

criteria. When patient is stable for discharge, review findings and recommendations for diet and managing nausea. Provide orders for necessary prescriptions, follow-up tests, and appointments to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021		
Presenter(s):	R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)		
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of American Gastrointestinal and Endoscopic Surgeons		
CPT Code:	43290		
Sample Size:	2328	**Resp N:**	51
Description of Sample:	The ACG, AGA and ASGE surveyed a random sample of 1,000 members; with email bouncebacks, 974 surveys were successfully delivered. SAGES surveyed the 160 members of their metabolic and bariatric surgeon and advanced endoscopy members. ASGE surveyed the 260 members of its Association for Bariatric Endoscopy (ABE). We also surveyed the 992 physician list provided by industry; with email bouncebacks, 934 surveys were successfully delivered. 974 (random sample) + 160 (SAGES metabolic and bariatric surgeon and advanced endoscopy group) + 260 (ASGE ABE) + 934 (Industry list) = 2,328		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	15.00	200.00
Survey RVW:	2.20	3.40	**3.50**	4.00	8.82
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**7.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.00**		
Intra-Service Time:	15.00	20.00	**30.00**	31.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	43290	**Recommended Physician Work RVU: 3.11**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

8A IV Sedation/Simple Procedure

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**20.00**	**25.00**	**50.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43212	000	3.40	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43226	000	2.24	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
10030	000	2.75	**RUC Time**	8,525

CPT Descriptor 1 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37191	000	4.46	**RUC Time**	25,555

CPT Descriptor 2 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 32 **% of respondents:** 62.7 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 11.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 43290	**Top Key Reference CPT Code:** 43212	**2nd Key Reference CPT Code:** **43226**
Median Pre-Service Time	26.00	26.00	22.00
Median Intra-Service Time	30.00	30.00	25.00
Median Immediate Post-service Time	20.00	20.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**76.00**	**76.00**	**57.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	760	0%	19%	28%	53%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	19%	78%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	34%	66%
Physical effort required	0%	31%	69%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	16%	81%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	83%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	0%	0%	100%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	16%	84%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal at the February 2021 CPT Editorial Panel meeting to add category I CPT codes for endoscopic bariatric device procedures to the esophagogastroduodenoscopy (EGD) code family. CPT code 43235 is the base code for the EGD family and was surveyed with the new endoscopic bariatric device procedures, 43290 and 43291.

43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

43290 with deployment of intragastric bariatric balloon

43291 with removal of intragastric bariatric balloon(s)

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43290 and 43291 together using both a random sample of the GI societies' memberships and a targeted survey of the ASGE Association for Bariatric Endoscopy (ABE), a vendor list from Apollo Endosurgery Inc. and SAGES' metabolic and bariatric surgeon and advanced endoscopy members. The Research Subcommittee also provided input on our reference service list.

Our multi-specialty consensus panel reviewed the survey data for codes 43235, 43290 and 43291, comparing the data and work RVUs (wRVUs) to the current data for similar 000-day global codes that were recently approved by the RUC.

43290 – Discussion and Recommendation

Code 43290 is a new code for deployment of gastric bariatric device under endoscopic guidance that was approved by the CPT Editorial Panel at its February 2021 meeting. The ACG, AGA, ASGE and SAGES conducted a survey for the April 2021 RUC meeting and received 51 responses: 22 from the targeted survey of the industry list, 6 from SAGES' metabolic and bariatric surgeon and advanced endoscopy members, 15 from the ASGE ABE (labeled "GI-targeted" in the Survey Summary Spreadsheet) and 8 from the random sample of the GI societies' membership.

43290 physician time recommendations:

Pre-time Package 2 (*Difficult Patient/Straightforward Procedure (No anesthesia care)*) is appropriate with 18 minutes of evaluation time, reflecting the current pre-service time, 3 minutes positioning time and 5 minutes scrub, dress, wait time.

Pre-service evaluation time: 18 minutes
Pre-service positioning time: 3 minutes
Pre-service scrub, dress, wait time: 5 minutes

A breakdown of the pre-service time is provided in the table below.

Detailed Description of Pre-Service Time Packages (Minutes)		
		FACILITY
		2
	Total Pre-Service Time	**26**
	CATEGORY SUBTOTALS	
A	Pre-Service Evaluation (IWPUT =0.0224)	18
B	Pre-Service Positioning (IWPUT = 0.0224)	3
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	5
	DETAILS	
A	History and Exam (Performance and review of appropriate Pre-Tests)	10
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3
A	Communicate with other professionals	0
A	Check/set-up room, supplies and equipment	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1
A	Prepare/ review/ confirm procedure	1
B	Perform/ supervise patient positioning	3
C	Administer local/topical anesthesia	0
C	Observe (wait anesthesia care)	0
C	Dress and scrub for procedure	5

Post-time Package 8A (*IV Sedation/ Straightforward Procedure*) is appropriate with 20 minutes of immediate post-service time, reflecting the survey median.

Intra-service time of 30 minutes is appropriate, reflecting the survey median.

Key Reference Services:
Two reference services were selected more often than others: 43212 and 43226. However, code 43212 (*Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)*) was selected most often (32/51).

43290 wRVU recommendation:
We originally recommended a wRVU of 3.40. This value is the 25th percentile of the combined survey data. The survey is robust and, thus, the 25th percentile is valid based on the amount of physician work and complexity involved. We felt the survey 25th percentile wRVU and median times fit well both within the EGD family and with other procedures and we provided tables showing its position both within the EGD family and within other recently valued 000-day global codes of similar intra-service and total time.

We note that in a comparison of recently RUC-reviewed 0-day global codes with similar intra-service and total times (see the table below), *code 43290 falls near the middle in terms of wRVUs with 29 codes above and 38 codes below 3.40 wRVUs*. There are many endoscopy codes that have similar intra-service time and higher wRVUs. We believe this supports the survey 25th percentile value.

CPT Code: 43290

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre S/D/W Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
36511	Therapeutic apheres	000	2.00	4	40			30	15	85	RUC	2017-01	PATHOLOGY	0.026		235
36513	Therapeutic apheres	000	2.00	4	40			25	15	80	RUC	2017-01	INTERVENTIONAL PAIN MGT	0.031		192
19281	Placement of breast	000	2.00	1a	13	1.0	6.0	30	15	65	RUC	2013-04	DIAGNOSTIC RADIOLOGY	0.043		30514
45337	Sigmoidoscopy, flexi	000	2.10	2b	20	3.0	5.0	25	15	68	RUC	2013-10	GASTROENTEROLOGY	0.048		1691
51727	Complex cystometro	000	2.11	5	20			35	10	65	RUC	2009-04	UROLOGY	0.041		1982
51728	Complex cystometro	000	2.11	5	20			35	10	65	RUC	2009-04	UROLOGY	0.041		85150
45341	Sigmoidoscopy, flexi	000	2.12	2b	20	3.0	5.0	30	15	73	RUC	2014-01	GASTROENTEROLOGY	0.041		2713
49185	Sclerotherapy of a fl	000	2.35	1a	13	3.0	6.0	30	15	67	RUC	2015-04	DIAGNOSTIC RADIOLOGY	0.054		2735
62305	Myelography via lum	000	2.35	1a	13	6.0	6.0	30	10	65	RUC	2014-04	DIAGNOSTIC RADIOLOGY	0.055		6616
36465	Injection of non-con	000	2.35	6	17	4.0	10.0	25	10	66	RUC	2017-01	VASCULAR SURGERY	0.063		30384
52005	Cystourethroscopy, v	000	2.37	1b	19	5.0	5.0	30	20	79	RUC	2010-10	UROLOGY	0.045	Yes	39015
43241	Esophagogastroduod	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	GASTROENTEROLOGY	0.057		4312
65779	Placement of amniot	000	2.50	1b	19	1.0	5.0	30	10	65	RUC-CMS	2015-04	OPHTHALMOLOGY	0.060		771
31623	Bronchoscopy, rigid (	000	2.63	1	10	5.0	5.0	30	15	65	RUC	2017-10	PULMONARY DISEASE	0.064		26278
31624	Bronchoscopy, rigid (	000	2.63	1	10	5.0	5.0	30	15	65	RUC	2017-10	PULMONARY DISEASE	0.064		118565
57156	Insertion of a vagina	000	2.69	2a	18	5.0	6.0	30	20	79	RUC	2010-02	RADIATION ONCOLOGY	0.056		15369
45347	Sigmoidoscopy, flexi	000	2.72	2b	23	3.0	5.0	35	15	81	RUC	2013-10	GASTROENTEROLOGY	0.050		637
10030	Image-guided fluid c	000	2.75	1b	16	5.0	5.0	30	20	76	RUC	2013-01	DIAGNOSTIC RADIOLOGY	0.060	Yes	8525
36200	Introduction of cath	000	2.77	2b	23	3.0	5.0	30	20	81	RUC	2011-02	VASCULAR SURGERY	0.057		23601
50436	Dilation of existing t	000	2.78	2	18	1.0	6.0	30	15	70	RUC	2018-01	DIAGNOSTIC RADIOLOGY	0.066		607
31646	Bronchoscopy, rigid (	000	2.78	1b	10	5.0	10.0	30	15	70	RUC	2016-10	PULMONARY DISEASE	0.068		4580
43231	Esophagoscopy, flexi	000	2.80	2b	23	3.0	5.0	30	20	81	RUC	2013-04	GASTROENTEROLOGY	0.058		502
31645	Bronchoscopy, rigid (	000	2.88	1b	10	5.0	10.0	35	15	75	RUC	2016-10	PULMONARY DISEASE	0.061		35233
50430	Injection procedure f	000	2.90	2b	20	1.0	5.0	35	20	81	RUC	2015-01	DIAGNOSTIC RADIOLOGY	0.056		1007
43252	Esophagogastroduod	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	GASTROENTEROLOGY	0.070		2273
36466	Injection of non-con	000	3.00	6	17	4.0	10.0	35	10	76	RUC	2017-01	GENERAL SURGERY	0.064		19877
62267	Percutaneous aspira	000	3.00	1b	14	10.0	10.0	30	15	79	RUC	2008-04	DIAGNOSTIC RADIOLOGY	0.068		2915
33997	Removal of percutan	000	3.00	2	18	1.0	6.0	30	20	75	RUC	2019-10		0.069		
52007	Cystourethroscopy, v	000	3.02	1b	19	5.0	5.0	32.5	20	81.5	RUC	2010-10	UROLOGY	0.061		349
44389	Colonoscopy throug	000	3.02	1b	14	2.0	5.0	30	14	65	RUC	2014-01	GASTROENTEROLOGY	0.077		2551
55874	Transperineal placen	000	3.03	1	13	6.0	6.0	30	15	70	RUC	2017-01	UROLOGY	0.074		12724
33993	Repositioning of per	000	3.10	2	18	1.0	6.0	25	20	70	RUC	2019-10	CARDIOLOGY	0.087		809
31256	Nasal/sinus endosco	000	3.11	3	15	8.0	10.0	30	20	83	RUC	2017-01	OTOLARYNGOLOGY	0.069		15592
31625	Bronchoscopy, rigid (	000	3.11	1b	10	3.0	5.0	35	15	68	RUC	2015-01	PULMONARY DISEASE	0.070		19149
32557	Pleural drainage, per	000	3.12	1a	13	3.0	6.0	30	15	67	RUC-CMS	2012-10	DIAGNOSTIC RADIOLOGY	0.079		38244
19081	Biopsy, breast, with	000	3.29	1a	13	3.0	6.0	30	15	67	RUC	2013-04	DIAGNOSTIC RADIOLOGY	0.085		60561
36901	Introduction of need	000	3.36	6B	17	4.0	5.0	25	15	66	RUC	2016-01	NEPHROLOGY	0.101		68183
52334	Cystourethroscopy w	000	3.37	2	18	6.0	6.0	30	15	75	RUC	2018-01	UROLOGY	0.082		289
43214	Esophagoscopy, flexi	000	3.40	2b	23	3.0	5.0	30	16	77	RUC	2013-01	OTOLARYNGOLOGY	0.081		215
43X21	Esophagogastroduod	000	3.40	2	18	3.0	5.0	30	20	76				0.081		
43212	Esophagoscopy, flexi	000	3.40	2b	23	3.0	5.0	30	15	76	RUC	2013-01	GASTROENTEROLOGY	0.081		585
43237	Esophagogastroduod	000	3.47	2b	20	3.0	5.0	35	20	83	RUC	2013-04	GASTROENTEROLOGY	0.071		18922
36482	Endovenous ablation	000	3.50	6	17	4.0	10.0	35	15	81	RUC	2017-01	CARDIOLOGY	0.075		47493
52214	Cystourethroscopy, v	000	3.50	1b	19	5.0	5.0	30	20	79	RUC	2012-01	UROLOGY	0.083		16853
36473	Endovenous ablation	000	3.50	6a	17	4.0	10.0	30	15	76	RUC	2017-01	VASCULAR SURGERY	0.087		6173
45349	Sigmoidoscopy, flexi	000	3.52	2b	15	3.0	5.0	30	15	68	RUC	2014-04	GASTROENTEROLOGY	0.091		632
43255	Esophagogastroduod	000	3.56	2b	23	3.0	5.0	30	20	81	RUC	2013-01	GASTROENTEROLOGY	0.083		62091
43246	Esophagogastroduod	000	3.56	2b	23	3.0	5.0	30	15	76	RUC	2013-04	GASTROENTEROLOGY	0.087		71081
45380	Colonoscopy, flexibl	000	3.56	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.100		1054879
45381	Colonoscopy, flexibl	000	3.56	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.100		82892
44390	Colonoscopy throug	000	3.74	2b	20	2.0	5.0	35	15	77	RUC	2014-01	GASTROENTEROLOGY	0.082		18
31629	Bronchoscopy, rigid (	000	3.75	1b	10	3.0	5.0	35	20	73	RUC	2015-01	PULMONARY DISEASE	0.085		13745
45386	Colonoscopy, flexibl	000	3.77	2b	20	3.0	5.0	35	15	78	RUC	2014-01	GASTROENTEROLOGY	0.082		2321
52441	Cystourethroscopy, v	000	4.00	3	26	5.0	10.0	25	15	81	RUC	2019-01	UROLOGY	0.116	Yes	26625
52224	Cystourethroscopy, v	000	4.05	5	19	5.0	5.0	30	20	79	RUC-CMS	2012-01	UROLOGY	0.101		36291
43233	Esophagogastroduod	000	4.07	2b	20	3.0	5.0	30	20	78	RUC	2013-01	GASTROENTEROLOGY	0.102		1577
45384	Colonoscopy, flexibl	000	4.07	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.118		77739
36215	Selective catheter pl	000	4.17	6b	17	3.0	5.0	30	20	75	RUC	2016-04	NEPHROLOGY	0.108		45269
45398	Colonoscopy, flexibl	000	4.20	2b	15	3.0	5.0	30	15	68	RUC	2014-01	GASTROENTEROLOGY	0.114		3509
43243	Esophagogastroduod	000	4.27	2b	23	3.0	5.0	30	20	81	RUC	2013-01	GASTROENTEROLOGY	0.107		647
31254	Nasal/sinus endosco	000	4.27	3	15	8.0	10.0	30	20	83	RUC	2017-01	OTOLARYNGOLOGY	0.108		13255
45379	Colonoscopy, flexibl	000	4.28	2b	15	3.0	5.0	35	15	73	RUC	2014-01	GASTROENTEROLOGY	0.100		930
33019	Pericardial drainage	000	4.29	2	30	5.0	6.0	28	15	84	RUC	2019-01		0.112		
43244	Esophagogastroduod	000	4.40	2b	23	3.0	5.0	30	20	81	RUC	2013-01	GASTROENTEROLOGY	0.111		22233
33016	Pericardiocentesis, ir	000	4.40	2	18	1.0	6.0	30	20	75	RUC	2019-01		0.116		
37191	Insertion of intravas	000	4.46	2b	20	3.0	5.0	30	15	73	RUC	2011-04	DIAGNOSTIC RADIOLOGY	0.119	Yes	25555
45385	Colonoscopy, flexibl	000	4.57	1	13	3.0	5.0	30	15	66	RUC	2019-04	GASTROENTEROLOGY	0.128		971282
52234	Cystourethroscopy, v	000	4.62	1b	19	5.0	5.0	30	20	79	RUC	2011-09	UROLOGY	0.120		28317
33017	Pericardial drainage	000	4.62	2	18	1.0	6.0	30	22	77	RUC	2019-01		0.122		
45388	Colonoscopy, flexibl	000	4.88	2b	15	3.0	5.0	35	15	73	RUC	2014-01	GASTROENTEROLOGY	0.117		26744

We also note that the 3.40 wRVU recommendation for 43290 fits appropriately within the EGD family, which additionally validates the survey 25th percentile wRVU (see the table below).

CPT Code	Short Desc	Global	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	IWPUT
43235	EGD base	000	2.09	1b	14	3.0	5.0	15	12	49	RUC	2013-01	0.093
43236	w/ submucoscal inj	000	2.39	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.082
43239	w/ biopsy	000	2.39	1b	13	3.0	5.0	17	12	50	RUC	2019-04	0.101
43241	w/ intraluminal tube/catheter insertion	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	0.057
43249	w/ balloon dilation esophagus <30mm diam	000	2.67	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.096
43X22	**w/ balloon removal**		**2.80**	**2**	**18**	**3.0**	**5.0**	**30**	**15**	**71**			**0.065**
43248	w/ insert guide wire dilator passage esophagus	000	2.91	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.108
43252	w/ optical endomicroscopy	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	0.070
43250	w/ flex removal lesion(s) by hot biopsy forceps	000	2.97	1b	11	3.0	5.0	20	14	53	RUC	2013-01	0.115
43245	w/ dilation gastric/duodenal stricture	000	3.08	2b	15	3.0	5.0	23	15	61	RUC	2013-01	0.100
43247	w/ removal of foreign body(s)	000	3.11	2b	13	3.0	5.0	30	15	58	RUC	2013-01	0.085
43X21	**w/ balloon placement**		**3.40**	**2**	**18**	**3.0**	**5.0**	**30**	**20**	**76**			**0.081**
43237	w/ EUS scope w/ adj strxrs	000	3.47	2b	20	3.0	5.0	35	20	83	RUC	2013-04	0.071
43251	w/ removal tumor polyp/other lesion snare tech	000	3.47	2b	15	3.0	5.0	20	10	53	RUC	2013-04	0.140
43246	w/ g-tube placement	000	3.56	2b	23	3.0	5.0	30	15	76	RUC	2013-04	0.087
43255	w/ control of bleeding	000	3.56	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.083
43266	w/ stent placement	000	3.92	2b	23	3.0	5.0	40	20	91	RUC	2013-01	0.071
43270	w/ ablate tumor polyp/lesion w/ dilation & wire	000	4.01	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.068
43259	w/ EUS exam surgical alter stom duodenum/jejunum	000	4.04	2b	23	3.0	5.0	45	20	96	RUC	2013-04	0.066
43233	w/ esophagus balloon dilation 33mm or larger	000	4.07	2b	20	3.0	5.0	30	20	78	RUC	2013-01	0.102
43257	w/ deliver thermal energy sphnctr/cardia GERD	000	4.15	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.071
43238	w/ intrmural US needle aspirate/biopsy esophags	000	4.16	2b	20	3.0	5.0	45	20	93	RUC	2013-04	0.070
43243	w/ injecton sclerosis esophgl/gastric varices	000	4.27	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.107
43244	w/ band ligation esophgeal/gastric varices	000	4.40	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.111
43242	w/ intrmural needle aspir/biop altered anatomy	000	4.73	2b	23	3.0	5.0	50	23	104	RUC	2013-04	0.072
43253	w/ EUS guided transmural injxn/fiducial marker	000	4.73	2b	23	3.0	5.0	40	23	94	RUC	2013-04	0.090
43254	w/ EMR	000	4.87	2b	20	3.0	5.0	45	20	93	RUC	2013-01	0.086
43240	w/ transoral transmural drainage pseudocyst	000	7.15	2b	23	3.0	5.0	70	30	131	RUC	2013-04	0.084
43210	w/ partial/compl esophagogastric fundoplasty	000	7.75	3	33	10.0	15.0	60	30	148	RUC-CMS	2015-04	0.100

We appreciate the time and effort our pre-facilitation reviewers took in helping us with this tab and explaining their concerns. Ultimately, they felt that the 25th percentile wRVU was too high in comparison to other services and recommended a crosswalk to 31256 (*Nasal/sinus endoscopy, surgical, with maxillary antrostomy;*) with 3.11 wRVUs, Pre-time Package #3 with 15 minutes of pre-service time, 30 minutes of intra-service time, 20 minutes post-service time and a total time of 83 minutes.

While we continue believe the survey 25th percentile wRVU accurately reflects the physician work involved and did our best to convey that in the materials we provided, we understand and respect the reviewers' advice that 3.40 wRVUs felt too high. We then turned our focus to crosswalks for codes with less than 3.40 wRVUs with 30 minutes of intra-service time and similar total times (see the table below).

Search criteria: 000 day global; wRVU<3.40; IS = 30 min; total time b/t 67-85 min; Most recent RUC review > 2007

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre SDW Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
43X21	**Esophagogastroduodenoscopy, flexible, transoral;**	**000**	**3.40**	**2**	**18**	**3.0**	**5.0**	**30**	**20**	**76**				**0.081**		
52334	Cystourethroscopy with insertion of ureteral guide w	000	3.37	2	18	6.0	6.0	30	15	75	RUC	2018-01	UROLOGY	0.0816		289
19081	Biopsy, breast, with placement of breast localization	000	3.29	1a	13	3.0	6.0	30	15	67	RUC	2013-04	DIAGNOSTIC RADI	0.0849		60561
32557	Pleural drainage, percutaneous, with insertion of ind	000	3.12	1a	13	3.0	6.0	30	15	67	RUC-CM	2012-10	DIAGNOSTIC RADI	0.0792		38244
31256	Nasal/sinus endoscopy, surgical, with maxillary antro	000	3.11	3	15	8.0	10.0	30	20	83	RUC	2017-01	OTOLARYNGOLOG	0.0689		15592
55874	Transperineal placement of biodegradable material,	000	3.03	1	13	6.0	6.0	30	15	70	RUC	2017-01	UROLOGY	0.074		12724
62267	Percutaneous aspiration within the nucleus pulposus	000	3.00	1b	14	10.0	10.0	30	15	79	RUC	2008-04	DIAGNOSTIC RADI	0.0682		2915
33997	Removal of percutaneous right heart ventricular ass	000	3.00	2	18	1.0	6.0	30	20	75	RUC	2019-10		0.0693		
43252	Esophagogastroduodenoscopy, flexible, transoral; w	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	GASTROENTEROL	0.0697		2273
43231	Esophagoscopy, flexible, transoral; with endoscopic	000	2.80	2b	23	3.0	5.0	30	20	81	RUC	2013-04	GASTROENTEROL	0.0576		502
31646	Bronchoscopy, rigid or flexible, including fluoroscopi	000	2.78	1b	10	5.0	10.0	30	15	70	RUC	2016-10	PULMONARY DISE	0.0676		4580
50436	Dilation of existing tract, percutaneous, for an endo	000	2.78	2	18	1.0	6.0	30	15	70	RUC	2018-01	DIAGNOSTIC RADI	0.0657		607
36200	Introduction of catheter, aorta	000	2.77	2b	23	3.0	5.0	30	20	81	RUC	2011-02	VASCULAR SURGE	0.0566		23601
10030	Image-guided fluid collection drainage by catheter (e	000	2.75	1b	16	5.0	5.0	30	20	76	RUC	2013-01	DIAGNOSTIC RADI	0.0597	Yes	8525
57156	Insertion of a vaginal radiation afterloading apparat	000	2.69	2a	18	5.0	6.0	30	20	79	RUC	2010-02	RADIATION ONCO	0.0559		15369
43241	Esophagogastroduodenoscopy, flexible, transoral; w	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	GASTROENTEROL	0.057		4312
52005	Cystourethroscopy, with ureteral catheterization, wi	000	2.37	1b	19	5.0	5.0	30	20	79	RUC	2010-10	UROLOGY	0.0448	Yes	39015
49185	Sclerotherapy of a fluid collection (eg, lymphocele, c	000	2.35	1a	13	3.0	6.0	30	15	67	RUC	2015-04	DIAGNOSTIC RADI	0.0536		2735
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound	000	2.12	2b	20	3.0	5.0	30	15	73	RUC	2014-01	GASTROENTEROL	0.0409		2713
36511	Therapeutic apheresis; for white blood cells	000	2.00	4	40			30	15	85	RUC	2017-01	PATHOLOGY	0.0256		235

Codes19081 and 52334 are candidates for potential crosswalk if the RUC is uncomfortable with the 43290 survey 25th percentile of 3.40 wRVUs. The reviewers specifically recommended 31256 with 3.11 wRVUs. Code 32557 is not an

ideal candidate because CMS did not accept the RUC's time recommendation. Codes below this wRVU would cause an anomaly with balloon removal code 43291 and within the EGD family.

The table below shows the crosswalk identified by the RUC reviewers (31256) and the two other potential crosswalk codes identified (19081 and 52334) highlighted in light orange and the original recommendation for 43290 to demonstrate how each would fit within the context of the EGD family.

CPT Code	Short Desc	Global	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	IWPUT
43235	**EGD base**	**000**	**2.09**	**1b**	**14**	**3.0**	**5.0**	**15**	**12**	**49**	**RUC**	**2013-01**	**0.093**
43236	w/ submucoscal inj	000	2.39	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.082
43239	w/ biopsy	000	2.39	1b	13	3.0	5.0	17	12	50	RUC	2019-04	0.101
43241	w/ intraluminal tube/catheter insertion	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	0.057
43249	w/ balloon dilation esophagus <30mm diam	000	2.67	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.096
43X22	**w/ balloon removal**	**000**	**2.80**	**2**	**18**	**3.0**	**5.0**	**30**	**15**	**71**			**0.065**
43248	w/ insert guide wire dilator passage esophagus	000	2.91	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.108
43252	w/ optical endomicroscopy	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	0.070
43250	w/ flex removal lesion(s) by hot biopsy forceps	000	2.97	1b	11	3.0	5.0	20	14	53	RUC	2013-01	0.115
43245	w/ dilation gastric/duodenal stricture	000	3.08	2b	15	3.0	5.0	23	15	61	RUC	2013-01	0.100
43247	w/ removal of foreign body(s)	000	3.11	2b	13	3.0	5.0	30	15	58	RUC	2013-01	0.085
31256	**RUC Reviewers' recommended Xwalk for 43X21 - Nasal/sinus endoscopy, surgical, with maxillary antrostomy;**	**000**	**3.11**	**3**	**15**	**8.0**	**10.0**	**30**	**20**	**83**	**RUC**	**2017-01**	**0.069**
19081	**Other potential Xwalk for 43X21 - Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**	**000**	**3.29**	**1a**	**13**	**3.0**	**6.0**	**30**	**15**	**67**	**RUC**	**2013-04**	**0.085**
52334	**Other potential Xwalk for 43X21 - Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde**	**000**	**3.37**	**2**	**18**	**6.0**	**6.0**	**30**	**15**	**75**	**RUC**	**2018-01**	**0.082**
43X21	**w/ balloon placement (25th percentile RVU)**	**000**	**3.40**	**2**	**18**	**3.0**	**5.0**	**30**	**20**	**76**			**0.081**
43237	w/ EUS scope w/ adj strxrs	000	3.47	2b	20	3.0	5.0	35	20	83	RUC	2013-04	0.071
43251	w/ removal tumor polyp/other lesion snare tech	000	3.47	2b	15	3.0	5.0	20	10	53	RUC	2013-04	0.140
43246	w/ g-tube placement	000	3.56	2b	23	3.0	5.0	30	15	76	RUC	2013-04	0.087
43255	w/ control of bleeding	000	3.56	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.083
43266	w/ stent placement	000	3.92	2b	23	3.0	5.0	40	20	91	RUC	2013-01	0.071
43270	w/ ablate tumor polyp/lesion w/ dilation & wire	000	4.01	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.068
43259	w/ EUS exam surgical alter stom duodenum/jejunum	000	4.04	2b	23	3.0	5.0	45	20	96	RUC	2013-04	0.066
43233	w/ esophagus balloon dilation 33mm or larger	000	4.07	2b	20	3.0	5.0	30	20	78	RUC	2013-01	0.102
43257	w/ deliver thermal energy sphnctr/cardia GERD	000	4.15	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.071
43238	w/ intrmural US needle aspirate/biopsy esophags	000	4.16	2b	20	3.0	5.0	45	20	93	RUC	2013-04	0.070
43243	w/ injecton sclerosis esophgl/gastric varices	000	4.27	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.107
43244	w/ band ligation esophgeal/gastric varices	000	4.40	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.111
43242	w/ intrmural needle aspir/biop altered anatomy	000	4.73	2b	23	3.0	5.0	50	23	104	RUC	2013-04	0.072
43253	w/ EUS guided transmural injxn/fiducial marker	000	4.73	2b	23	3.0	5.0	40	23	94	RUC	2013-04	0.090
43254	w/ EMR	000	4.87	2b	20	3.0	5.0	45	20	93	RUC	2013-01	0.086
43240	w/ transoral transmural drainage pseudocyst	000	7.15	2b	23	3.0	5.0	70	30	131	RUC	2013-04	0.084
43210	w/ partial/compl esophagogastric fundoplasty	000	7.75	3	33	10.0	15.0	60	30	148	RUC-CMS	2015-04	0.100

While we continue believe the survey 25th percentile wRVU accurately reflects the physician work involved and did our best to convey that in the materials we provided, **we will move forward with the RUC reviewers' recommendation to crosswalk the value of 43290 to code 31256 at 3.11 wRVUs**.

The table below pertains to the next section on SERVICES REPORTED WITH MULTIPLE CPT CODES:

Balloon placement (43X21) with moderate sedation provided by same physician

Provider	CPT	Description	Global	wRVU / Base Unit	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X21	Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance	000	3.40 wRVU (proposed)	26	30	20	No
GI or endoscopic surgeon	99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	XXX	0.25 wRVU	0	12	0	No
GI or endoscopic surgeon	99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	XXX	0.00 wRVU	0	0	0	No

Balloon placement (43X21) with anesthesia

Provider	CPT	Description	Global	wRVU / Base Unit	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X21	Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance	000	3.40 wRVU (proposed)	26	30	20	No
Anesthesia professional	00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	XXX	5 base units	19	25	10	No

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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 43290 is typically performed with either moderate sedation or anesthesia. When moderate sedation was removed from GI endoscopy codes and other codes where moderate sedation was considered inherent to the procedure, it became historical precedent that moderate sedation is separately reported. Codes 99152 and 99153 or 00731 would be reported typically on the same date with 43290. No multiple procedures reduction policies apply. See section above for a table including CPT codes, global period, work RVUs, pre, intra and post-time and performing physician.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The CPT application indicates 15% of endoscopic bariatric balloon placement was reported with 43999.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty General Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7571
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Apollo Endosurgery estimates 7,571 devices were placed in 2018

Specialty Gastroenterology Frequency 5300 Percentage 70.00 %

Specialty General Surgery Frequency 2272 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,523
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS volume is estimated to be 1/3 of national volume (7,571/3 = 2,523)

Specialty Gastroenterology Frequency 1767 Percentage 70.03 %

Specialty General Surgery Frequency 757 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Endoscopy

BETOS Sub-classification Level II:
Upper Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43215

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43291 Tracking Number B3 Original Specialty Recommended RVU: **2.80**
Presented Recommended RVU: **2.80**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **2.80**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female presented who is six months post placement of an intragastric balloon presents for removal of the balloon.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review procedural history of balloon placement and symptoms since balloon placement. Confirm the amount of fluid (in ccs/mls) that was used to inflate the balloon. Review patient's allergies and medications, specifically noting usage of antiplatelet or anticoagulation medications. Discuss case planning with anesthesia team. Review patient's laboratory studies as they relate to coagulation status and platelet count. Review patient's other diagnostic tests. Review the risks and benefits of the procedure. Obtain informed consent. Verify all endoscopic equipment is available and operational and make appropriate computer entries as necessary. Position patient on the examination table. Position endoscopic equipment to provide access for the procedure. Perform a time out. Place a bite-block in patient's mouth.

Description of Intra-Service Work: Assess level of sedation prior to inserting the endoscope. Insert a standard flexible upper endoscope through the mouth into the oropharynx and advance through the esophagus into the proximal stomach. Insufflate the stomach with air after suctioning liquid contents. Perform an examination of the entire stomach in the forward and retroflexed positions. Inspect the duodenum circumferentially after air insufflation. Slowly withdraw the endoscope and reinspect the stomach and duodenum. Visualize the previously placed balloon. Insert a needle instrument through the working channel of the endoscope. Use the needle instrument to puncture the balloon. Attach the external portion of the needle catheter to suction and remove the fluid from the balloon. The volume of the fluid is measured to ensure it approximates the same amount that was used to fill the balloon. After careful inspection to ensure the balloon is fully deflated, the needle catheter is removed. The device specific retrieval instrument is used to grasp the deflated balloon. The balloon is brought in apposition to the endoscope. The endoscope and balloon are carefully removed perorally using direct endoscopic guidance. The endoscope is then reinserted to make sure there is no mucosal trauma in the upper gastrointestinal tract. The endoscope is advanced through the pylorus into the duodenal bulb. The stomach is reinsuflated. The remaining fluid is removed. The stomach and esophagus are carefully evaluated, allowing measurement of the squamocolumnar (SC) and gastroesophageal (GE) junction from the incisors. Assess for presence of a hiatal hernia and examine the esophageal mucosa. When indicated, obtain brushings or washings of suspicious abnormalities. Obtain photodocumentation of appropriate normal landmarks and abnormalities. The endoscope is then removed and the procedure is complete.

Description of Post-Service Work: Assess patient's condition including post-procedure vital signs. Complete post-procedure orders. Review and label photographs. Generate a procedure report and forward to referral source and other appropriate parties. Assess patient for suitability to discharge from the recovery suite relative to established discharge

criteria. When patient is stable for discharge, review findings and recommendations with the patient and pertinent others. Provide orders for necessary prescriptions, follow-up tests, and appointments to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021		
Presenter(s):	R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)		
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of American Gastrointestinal and Endoscopic Surgeons		
CPT Code:	43291		
Sample Size:	2328	**Resp N:**	51
Description of Sample:	The ACG, AGA and ASGE surveyed a random sample of 1,000 members; with email bouncebacks, 974 surveys were successfully delivered. SAGES surveyed the 160 members of their metabolic and bariatric surgeon and advanced endoscopy members. ASGE surveyed the 260 members of its Association for Bariatric Endoscopy (ABE). We also surveyed the 992 physician list provided by industry; with email bouncebacks, 934 surveys were successfully delivered. 974 (random sample) + 160 (SAGES metabolic and bariatric surgeon and advanced endoscopy group) + 260 (ASGE ABE) + 934 (Industry list) = 2,328		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	14.00	200.00
Survey RVW:	2.44	2.80	**3.50**	3.84	10.50
Pre-Service Evaluation Time:			**34.00**		
Pre-Service Positioning Time:			**7.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.00**		
Intra-Service Time:	14.00	20.00	**30.00**	35.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	43291	**Recommended Physician Work RVU: 2.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43215	000	2.44	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with removal of foreign body(s)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43212	000	3.40	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.53	**RUC Time**	6,254,698

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37191	000	4.46	**RUC Time**	6,976,757

CPT Descriptor 2 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 54.9 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 43291	**Top Key Reference CPT Code:** 43215	**2nd Key Reference CPT Code:** **43212**
Median Pre-Service Time	26.00	23.00	31.00
Median Intra-Service Time	30.00	20.00	30.00
Median Immediate Post-service Time	15.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**71.00**	**53.00**	**76.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	11%	46%	43%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	18%	82%
Physical effort required	4%	11%	85%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	14%	86%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	17%	42%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	17%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	8%	84%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal at the February 2021 CPT Editorial Panel meeting to add category I CPT codes for endoscopic bariatric device procedures to the esophagogastroduodenoscopy (EGD) code family. CPT code 43235 is the base code for the EGD family and was surveyed with the new endoscopic bariatric device procedures, 43290 and 43291.

43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

43290 with deployment of intragastric bariatric balloon

43291 with removal of intragastric bariatric balloon(s)

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43290 and 43291 together using both a random sample of the GI societies' memberships and a targeted survey of the ASGE Association for Bariatric Endoscopy (ABE), a vendor list from Apollo Endosurgery Inc. and SAGES' metabolic and bariatric surgeon and advanced endoscopy members. The Research Subcommittee also provided input on our reference service list.

Our multi-specialty consensus panel reviewed the survey data for codes 43235, 43290 and 43291, comparing the data and work RVUs (wRVUs) to the current data for similar 000-day global codes that were recently approved by the RUC.

43291 – Discussion and Recommendation

Code 43291 is a new code for removal of intragastric bariatric balloon(s) that was approved by the CPT Editorial Panel at its February 2021 meeting. The ACG, AGA, ASGE and SAGES conducted a survey for the April 2021 RUC meeting and received 51 responses: 22 from the targeted survey of the industry list, 6 from SAGES' metabolic and bariatric surgeon and advanced endoscopy members, 15 from the ASGE ABE (labeled "GI-targeted" in the Survey Summary Spreadsheet) and 8 from the random sample of the GI societies' membership.

We recommend the existing **wRVU of 2.80**. This value is the 25th percentile of the combined survey data.

Pre-time Package 2 (*Difficult Patient/Straightforward Procedure (No anesthesia care)*) is appropriate with 18 minutes of evaluation time, reflecting the current pre-service time, 3 minutes positioning time and 5 minutes scrub, dress, wait time.

Pre-service evaluation time: 18 minutes
Pre-service positioning time: 3 minutes
Pre-service scrub, dress, wait time: 5 minutes

Please see the breakdown of pre-service minutes in the table below.

Detailed Description of Pre-Service Time Packages (Minutes)		
		FACILITY
		2
	Total Pre-Service Time	**26**
	CATEGORY SUBTOTALS	
A	Pre-Service Evaluation (IWPUT =0.0224)	18
B	Pre-Service Positioning (IWPUT = 0.0224)	3
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	5
	DETAILS	
A	History and Exam (Performance and review of appropriate Pre-Tests)	10
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3
A	Communicate with other professionals	0
A	Check/set-up room, supplies and equipment	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1
A	Prepare/ review/ confirm procedure	1
B	Perform/ supervise patient positioning	3
C	Administer local/topical anesthesia	0
C	Observe (wait anesthesia care)	0
C	Dress and scrub for procedure	5

Post-time Package 9A (*General Anesthesia or Complex Regional Block/ Straightforward Procedure*) is appropriate with 15 minutes of immediate post-service time, reflecting the survey median post-service time.

Intra-service time of 30 minutes is appropriate, reflecting the survey median.

Key Reference Services
Two reference services were selected more often than others: 43215 and 43212. However, code 43215 (*Esophagoscopy, flexible, transoral; with removal of foreign body(s)*) was selected most often (28/51).

Comparison to recently RUC-reviewed 0-day global codes with 30 minutes intra-service time and similar total time:

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre S/D/W Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
44381	Ileoscopy, through st	000	1.38	2b	15	1.0	5.0	25	15	61	RUC	2013-10	GASTROENTEROLOGY	0.0258		150
36569	Insertion of peripher	000	1.90	1	13	3.0	6.0	27	11	60	RUC	2018-01	PHYSICIANS ASSISTANT	0.0462		14961
36513	Therapeutic apheres	000	2.00	4	40			25	15	80	RUC	2017-01	INTERVENTIONAL PAIN MGT	0.0307		192
19281	Placement of breast	000	2.00	1a	13	1.0	6.0	30	15	65	RUC	2013-04	DIAGNOSTIC RADIOLOGY	0.0434		30514
49083	Abdominal paracent	000	2.00	1a	15	5.0	5.0	25	10	60	RUC	2010-10	DIAGNOSTIC RADIOLOGY	0.0515		265269
45337	Sigmoidoscopy, flexi	000	2.10	2b	20	3.0	5.0	25	15	68	RUC	2013-10	GASTROENTEROLOGY	0.0483		1691
51727	Complex cystometro	000	2.11	5	20			35	10	65	RUC	2009-04	UROLOGY	0.0411		1982
51728	Complex cystometro	000	2.11	5	20			35	10	65	RUC	2009-04	UROLOGY	0.0411		85150
45341	Sigmoidoscopy, flexi	000	2.12	2b	20	3.0	5.0	30	15	73	RUC	2014-01	GASTROENTEROLOGY	0.0409		2713
46607	Anoscopy; with high-	000	2.20	6a	17	5.0	5.0	25	10	62	RUC	2014-04	COLORECTAL SURGERY (PROCT)	0.0577		2471
43206	Esophagoscopy, flexi	000	2.29	1b	14	3.0	5.0	30	10	62	RUC	2012-10	GASTROENTEROLOGY	0.0548		21
62302	Myelography via lum	000	2.29	1a	13	5.0	6.0	26	10	60	RUC	2014-04	DIAGNOSTIC RADIOLOGY	0.0621		4191
49185	Sclerotherapy of a flu	000	2.35	1a	13	3.0	6.0	30	15	67	RUC	2015-04	DIAGNOSTIC RADIOLOGY	0.0536		2735
62305	Myelography via lum	000	2.35	1a	13	6.0	6.0	30	10	65	RUC	2014-04	DIAGNOSTIC RADIOLOGY	0.0551		6616
36465	Injection of non-com	000	2.35	6	17	4.0	10.0	25	10	66	RUC	2017-01	VASCULAR SURGERY	0.063		30384
52005	Cystourethroscopy, v	000	2.37	1b	19	5.0	5.0	30	20	79	RUC	2010-10	UROLOGY	0.0448	Yes	39015
20225	Biopsy, bone, trocar,	000	2.45	2	7	6.0	6.0	30	15	64	RUC	2019-01	DIAGNOSTIC RADIOLOGY	0.0591		14341
30906	Control nasal hemor	000	2.45	6a	12	1.0	5.0	30	15	63	RUC	2016-04	OTOLARYNGOLOGY	0.0594		800
43241	Esophagogastroduod	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	GASTROENTEROLOGY	0.057		4312
65779	Placement of amniot	000	2.50	1b	19	1.0	5.0	30	10	65	RUC-CMS	2015-04	OPHTHALMOLOGY	0.0596		771
31622	Bronchoscopy, rigid (	000	2.53	1b	8	3.0	5.0	30	15	61	RUC	2015-01	PULMONARY DISEASE	0.0636	Yes	52315
31623	Bronchoscopy, rigid (	000	2.63	1	10	5.0	5.0	30	15	65	RUC	2017-10	PULMONARY DISEASE	0.0639		26278
31624	Bronchoscopy, rigid (	000	2.63	1	10	5.0	5.0	30	15	65	RUC	2017-10	PULMONARY DISEASE	0.0639		118565
57156	Insertion of a vagina	000	2.69	2a	18	5.0	6.0	30	20	79	RUC	2010-02	RADIATION ONCOLOGY	0.0559		15369
44388	Colonoscopy through	000	2.72	1b	14	2.0	5.0	25	14	60	RUC	2014-01	GASTROENTEROLOGY	0.0803		4180
10030	Image-guided fluid c	000	2.75	1b	16	5.0	5.0	30	20	76	RUC	2013-01	DIAGNOSTIC RADIOLOGY	0.0597	Yes	8525
50436	Dilation of existing t	000	2.78	2	18	1.0	6.0	30	15	70	RUC	2018-01	DIAGNOSTIC RADIOLOGY	0.0657		607
31646	Bronchoscopy, rigid (	000	2.78	1b	10	5.0	10.0	30	15	70	RUC	2016-10	PULMONARY DISEASE	0.0676		4580
43X22	Esophagogastroduod	000	2.80	2	18	3	5	30	15	71						
43217	Esophagoscopy, flexi	000	2.80	2b	15	3.0	5.0	30	10	63	RUC	2012-10	GASTROENTEROLOGY	0.0711		53
31645	Bronchoscopy, rigid (	000	2.88	1b	10	5.0	10.0	35	15	75	RUC	2016-10	PULMONARY DISEASE	0.0608		35233
43227	Esophagoscopy, flexi	000	2.89	2b	15	3.0	5.0	30	10	63	RUC	2012-10	GASTROENTEROLOGY	0.0741		191
43252	Esophagogastroduod	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	GASTROENTEROLOGY	0.0697		2273
36466	Injection of non-com	000	3.00	6	17	4.0	10.0	35	10	76	RUC	2017-01	GENERAL SURGERY	0.0636		19877
62267	Percutaneous aspira	000	3.00	1b	14	10.0	10.0	30	15	79	RUC	2008-04	DIAGNOSTIC RADIOLOGY	0.0682		2915
33997	Removal of percutan	000	3.00	2	18	1.0	6.0	30	20	75	RUC	2019-10		0.0693		
44389	Colonoscopy through	000	3.02	1b	14	2.0	5.0	30	14	65	RUC	2014-01	GASTROENTEROLOGY	0.0769		2551
44404	Colonoscopy through	000	3.02	1b	14	2.0	5.0	30	10	61	RUC	2014-01	GASTROENTEROLOGY	0.0799		190
55874	Transperineal placer	000	3.03	1	13	6.0	6.0	30	15	70	RUC	2017-01	UROLOGY	0.074		12724
33993	Repositioning of per	000	3.10	2	18	1.0	6.0	25	20	70	RUC	2019-10	CARDIOLOGY	0.0871		809
31296	Nasal/sinus endosco	000	3.10	6	15	1.0	5.0	25	15	61	RUC	2017-01	OTOLARYNGOLOGY	0.0946		8725
31625	Bronchoscopy, rigid (	000	3.11	1b	10	3.0	5.0	35	15	68	RUC	2015-01	PULMONARY DISEASE	0.0698		19149
32557	Pleural drainage, per	000	3.12	1a	13	3.0	6.0	30	15	67	RUC-CMS	2012-10	DIAGNOSTIC RADIOLOGY	0.0792		38244
45378	Colonoscopy, flexible	000	3.26	1b	14	3.0	5.0	25	15	62	RUC	2014-01	GASTROENTEROLOGY	0.1001		345987
19081	Biopsy, breast, with	000	3.29	1a	13	3.0	6.0	30	15	67	RUC	2013-04	DIAGNOSTIC RADIOLOGY	0.0849		60561
36901	Introduction of need	000	3.36	6B	17	4.0	5.0	25	15	66	RUC	2016-01	NEPHROLOGY	0.1005		68183
52334	Cystourethroscopy w	000	3.37	2	18	6.0	6.0	30	15	75	RUC	2018-01	UROLOGY	0.0816		289
43214	Esophagoscopy, flexi	000	3.40	2b	23	3.0	5.0	30	16	77	RUC	2013-01	OTOLARYNGOLOGY	0.0806		215
43212	Esophagoscopy, flexi	000	3.40	2b	23	3.0	5.0	30	15	76	RUC	2013-01	GASTROENTEROLOGY	0.0814		585
52214	Cystourethroscopy, v	000	3.50	1b	19	5.0	5.0	30	20	79	RUC	2012-01	UROLOGY	0.0825		16853
36473	Endovenous ablation	000	3.50	6a	17	4.0	10.0	30	15	76	RUC	2017-01	VASCULAR SURGERY	0.0871		6173
45349	Sigmoidoscopy, flexi	000	3.52	2b	15	3.0	5.0	30	15	68	RUC	2014-04	GASTROENTEROLOGY	0.0913		632
44392	Colonoscopy through	000	3.53	1b	14	2.0	5.0	30	10	61	RUC	2014-01	GASTROENTEROLOGY	0.0969		297
43246	Esophagogastroduod	000	3.56	2b	23	3.0	5.0	30	15	76	RUC	2013-04	GASTROENTEROLOGY	0.0867		71081
45380	Colonoscopy, flexible	000	3.56	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.1001		1054879
45381	Colonoscopy, flexible	000	3.56	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.1001		82892
44390	Colonoscopy through	000	3.74	2b	20	2.0	5.0	35	15	77	RUC	2014-01	GASTROENTEROLOGY	0.082		18
31629	Bronchoscopy, rigid (	000	3.75	1b	10	3.0	5.0	35	20	73	RUC	2015-01	PULMONARY DISEASE	0.0849		13745
45386	Colonoscopy, flexible	000	3.77	2b	20	3.0	5.0	35	15	78	RUC	2014-01	GASTROENTEROLOGY	0.0822		2321
52224	Cystourethroscopy, v	000	4.05	5	19	5.0	5.0	30	20	79	RUC-CMS	2012-01	UROLOGY	0.1008		36291
43233	Esophagogastroduod	000	4.07	2b	20	3.0	5.0	30	20	78	RUC	2013-01	GASTROENTEROLOGY	0.1022		1577
45384	Colonoscopy, flexible	000	4.07	1b	14	3.0	5.0	28	15	65	RUC	2014-01	GASTROENTEROLOGY	0.1183		77739
36215	Selective catheter pl	000	4.17	6b	17	3.0	5.0	30	20	75	RUC	2016-04	NEPHROLOGY	0.1078		45269
45398	Colonoscopy, flexible	000	4.20	2b	15	3.0	5.0	30	15	68	RUC	2014-01	GASTROENTEROLOGY	0.114		3509
45379	Colonoscopy, flexible	000	4.28	2b	15	3.0	5.0	35	15	73	RUC	2014-01	GASTROENTEROLOGY	0.1		930
44401	Colonoscopy through	000	4.34	2b	15	2.0	5.0	30	10	62	RUC	2014-01	GASTROENTEROLOGY	0.1232		65
33016	Pericardiocentesis, in	000	4.40	2	18	1.0	6.0	30	20	75	RUC	2019-01		0.1159		
37191	Insertion of intravas	000	4.46	2b	20	3.0	5.0	30	15	73	RUC	2011-04	DIAGNOSTIC RADIOLOGY	0.1189	Yes	25555
45385	Colonoscopy, flexible	000	4.57	1	13	3.0	5.0	30	15	66	RUC	2019-04	GASTROENTEROLOGY	0.1278		971282
52234	Cystourethroscopy, v	000	4.62	1b	19	5.0	5.0	30	20	79	RUC	2011-09	UROLOGY	0.1198		28317
33017	Pericardial drainage	000	4.62	2	18	1.0	6.0	30	22	77	RUC	2019-01		0.1218		
45388	Colonoscopy, flexible	000	4.88	2b	15	3.0	5.0	35	15	73	RUC	2014-01	GASTROENTEROLOGY	0.1172		26744

43291 comparison to codes in the EGD family

CPT Code	Short Desc	Global	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Immed Post Time	Total Time	Time Source	Most Recent RUC Review	IWPUT
43235	EGD base	000	2.09	1b	14	3.0	5.0	15	12	49	RUC	2013-01	0.093
43236	w/ submucoscal inj	000	2.39	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.082
43239	w/ biopsy	000	2.39	1b	13	3.0	5.0	17	12	50	RUC	2019-04	0.101
43241	w/ intraluminal tube/catheter insertion	000	2.49	2b	15	3.0	5.0	30	15	68	RUC	2013-01	0.057
43249	w/ balloon dilation esophagus <30mm diam	000	2.67	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.096
43X22	**w/ balloon removal**		**2.80**	**2**	**18**	**3.0**	**5.0**	**30**	**15**	**71**			**0.065**
43248	w/ insert guide wire dilator passage esophagus	000	2.91	1b	14	3.0	5.0	20	15	57	RUC	2013-01	0.108
43252	w/ optical endomicroscopy	000	2.96	1b	14	3.0	5.0	30	20	72	RUC	2013-01	0.070
43250	w/ flex removal lesion(s) by hot biopsy forceps	000	2.97	1b	11	3.0	5.0	20	14	53	RUC	2013-01	0.115
43245	w/ dilation gastric/duodenal stricture	000	3.08	2b	15	3.0	5.0	23	15	61	RUC	2013-01	0.100
43247	w/ removal of foreign body(s)	000	3.11	2b	13	3.0	5.0	30	15	58	RUC	2013-01	0.085
43X21	**w/ balloon placement**		**3.40**	**2**	**18**	**3.0**	**5.0**	**30**	**20**	**76**			**0.081**
43237	w/ EUS scope w/ adj strxrs	000	3.47	2b	20	3.0	5.0	35	20	83	RUC	2013-04	0.071
43251	w/ removal tumor polyp/other lesion snare tech	000	3.47	2b	15	3.0	5.0	20	10	53	RUC	2013-04	0.140
43246	w/ g-tube placement	000	3.56	2b	23	3.0	5.0	30	15	76	RUC	2013-04	0.087
43255	w/ control of bleeding	000	3.56	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.083
43266	w/ stent placement	000	3.92	2b	23	3.0	5.0	40	20	91	RUC	2013-01	0.071
43270	w/ ablate tumor polyp/lesion w/ dilation & wire	000	4.01	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.068
43259	w/ EUS exam surgical alter stom duodenum/jejunum	000	4.04	2b	23	3.0	5.0	45	20	96	RUC	2013-04	0.066
43233	w/ esophagus balloon dilation 33mm or larger	000	4.07	2b	20	3.0	5.0	30	20	78	RUC	2013-01	0.102
43257	w/ deliver thermal energy sphnctr/cardia GERD	000	4.15	2b	23	3.0	5.0	45	15	91	RUC	2013-01	0.071
43238	w/ intrmural US needle aspirate/biopsy esophags	000	4.16	2b	20	3.0	5.0	45	20	93	RUC	2013-04	0.070
43243	w/ injecton sclerosis esophgl/gastric varices	000	4.27	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.107
43244	w/ band ligation esophgeal/gastric varices	000	4.40	2b	23	3.0	5.0	30	20	81	RUC	2013-01	0.111
43242	w/ intrmural needle aspir/biop altered anatomy	000	4.73	2b	23	3.0	5.0	50	23	104	RUC	2013-04	0.072
43253	w/ EUS guided transmural injxn/fiducial marker	000	4.73	2b	23	3.0	5.0	40	23	94	RUC	2013-04	0.090
43254	w/ EMR	000	4.87	2b	20	3.0	5.0	45	20	93	RUC	2013-01	0.086
43240	w/ transoral transmural drainage pseudocyst	000	7.15	2b	23	3.0	5.0	70	30	131	RUC	2013-04	0.084
43210	w/ partial/compl esophagogastric fundoplasty	000	7.75	3	33	10.0	15.0	60	30	148	RUC-CMS	2015-04	0.100

This table is for the "Services Reported with Multiple CPT Codes" section below.

Balloon removal (43X22) with moderate sedation provided by same physician

Provider	CPT	Description	Global	wRVU	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X22	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000	2.80	26	30	15	No
GI or endoscopic surgeon	99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	XXX	0.25	0	12	0	No
GI or endoscopic surgeon	99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	XXX	0.00	0	0	0	No

Balloon removal (43X22) with anesthesia

Provider	CPT	Description	Global	wRVU	Pre-service time	Intra-service time	Post-service time	Overlapping procedure work?
GI or endoscopic surgeon	43X22	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000	2.80	26	30	15	No
Anesthesia professional	00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	XXX	5.00	19	25	10	No

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 43291 is typically performed with either moderate sedation or anesthesia. When moderate sedation was removed from GI endoscopy codes and other codes where moderate sedation was considered inherent to the procedure, it became historical precedent that moderate sedation is separately reported. Codes 99152 and 99153 or 00731 would be reported typically on the same date with 43291. No multiple procedures reduction policies apply. See SOR 43291 Attachment for a table including CPT codes, global period, work RVUs, pre, intra and post-time and performing physician.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 43247 was previously used to report removal of bariatric balloon devices.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty General Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7571
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Apollo Endosurgery estimates 7,571 devices were placed in 2018; therefore, 7,571 devices were removed

Specialty Gastroenterology Frequency 5300 Percentage 70.00 %

Specialty General Surgery Frequency 2272 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,523
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS volume is estimated to be 1/3 of national volume (7,571/3 = 2,523)

Specialty Gastroenterology Frequency 1767 Percentage 70.03 %

Specialty General Surgery Frequency 757 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Endoscopy

BETOS Sub-classification Level II:
Upper Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43215

SS Rec Summary

ISSUE: Endoscopic Bariatric Device Procedures

TAB: 8

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	43202	000	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	2012	26	0.072	0.037			1.72			47	14	3	5			15			10					
2nd REF	43216	000	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2012	5	0.074	0.042			2.30			55	15	3	5			22			10					
CURRENT	43235	000	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2013		0.093	0.043			2.09			49	14	3	5			15			12					
SVY - all data	43235	000	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by		54	0.086	0.037	1.50	2.10	2.25	2.50	4.00	61	23	5	5	7	11	15	20	30	13	0	50	135	300	1000
REC	43235	000	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)			0.093	0.043			2.09			49	14	3	5			15			12					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	43212	000	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2013	32	0.081	0.045			3.40			76	23	3	5			30			15					
2nd REF	43226	000	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2012	6	0.064	0.039			2.24			57	14	3	5			25			10					
SVY - all data	43290	000	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon		51	0.065	0.034	2.20	3.40	3.50	4.00	8.82	103	40	7	6	15	20	30	31	60	20	0	0	5	15	200
Xwalk	31256	000	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	2017		0.069	0.037			3.11			83	15	8	10			30			20					
REC	43290	000	Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance			0.072	0.041			3.11			76	18	3	5			30			20					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	43215	000	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2012	28	0.089	0.046			2.44			53	15	3	5			20			10					
2nd REF	43212	000	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2013	12	0.081	0.045			3.40			76	23	3	5			30			15					
SVY - all data	43291	000	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)		51	0.073	0.038	2.44	2.80	3.50	3.84	10.50	92	34	7	6	14	20	30	35	60	15	0	0	5	14	200
REC	43291	000	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)			0.065	0.039			2.80			71	18	3	5			30			15					

FACILITY DIRECT PE INPUTS **CPT CODE(S):**43235, 43290, 43291

SPECIALTY SOCIETY(IES): ACG, AGA, ASGE, SAGES

PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE), Sheth Ketan, MD (SAGES), Dmitry Nepomnayshy, MD (SAGES)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	000
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
43235	A 67-year-old patient with dyspepsia and weight loss refractory to pharmacological therapy is referred for diagnostic esophagogastroduodenoscopy (EGD) and collection of specimens by brushings.
43290	A 45-year-old female with a body mass index (BMI) of 33 who has failed to respond to dietary and pharmacologic interventions for weight loss undergoes endoscopically guided insertion of a gastric balloon.
43291	A 45-year-old female who is six months post placement of an intragastric balloon presents for removal of the balloon.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The ACG, AGA, ASGE and SAGES convened an RVS expert panel of the surveying specialty societies to review practice expense data for codes 43235, 43290 and 43291. The panel included both sub-specialists and generalists from within the specialties of a variety of settings across the United States. They also received input from practice managers and clinical staff familiar with the direct expense inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code for comparison of 43235 is 43235 with current PE inputs.

   The reference code for comparison of 43290 is 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire). Code 43215 was selected because it is most similar to removal of intragastric bariatric balloon(s).
   The reference code for comparison of 43291 is 43215 (Esophagoscopy, flexible, transoral; with removal of foreign body(s)). Code 43215 was selected because it is most similar to removal of intragastric bariatric balloon(s).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

3. Is this code(s) typically reported with an E/M service?

43235 is not typically reported with an E/M service. According to the RUC database, 43235 was billed 1.0% of the time with office E/M. It is not typically reported with an E/M service in the non-facility. According to the RUC database, 43235 was billed 7.0% of the time with non-facility office E/M.

Codes 43290 and 43291 are new CPT codes, so there is no data available for them in the RUC database. However, we do not expect these codes to be typically reported with an E/M service or with an E/M service in the non-facility.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Not applicable. We are not requesting more minutes that the PE Subcommittee standards.

		Approved by PE Subcmte Oct 2012	GI/SAGES Recommendation		
		Facility	43235	43X21	43X22
Activity Code	Description of Clinical Actvities	Use of Clinical Staff for Endoscopy	EGD base code	Balloon placement	Balloon removal
CA001	Complete pre-service diagnostic and referral forms	3	3	3	3
CA002	Coordinate pre-surgery services (including test results)	5	5	5	5
CA003	Schedule space and equipment in facility	3	3	3	3
CA004	Provide pre-service education/obtain consent	5	5	5	5
CA005	Complete pre-procedure phone calls and prescription	3	3	3	3
	Other Clinical Activity	0	0	0	0
	TOTAL	**19**	**19**	**19**	**19**

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

43235, 43290 and 43291 Pre-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to complete pre-service diagnostic and referral forms (CA001)
- 5 minutes to coordinate pre-surgery services (including test results) (CA002)
- 3 minutes to schedule space and equipment in facility (CA003)
- 5 minutes to provide pre-service education/obtain consent (CA004)
- 3 minutes to complete pre-procedure phone calls and prescription (CA005)

b. Service period (includes pre, intra and post):

N/A

c. Post-service period:

43235, 43290 and 43291 Post-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to conduct patient communications (CA037)

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

43235 = 43235 43290 and 43291 = 43215 (*Esophagoscopy, flexible, transoral; with removal of foreign body(s)*)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):**43235, 43290, 43291
SPECIALTY SOCIETY(IES): ACG, AGA, ASGE, SAGES
PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE), Sheth Ketan, MD (SAGES), Dmitry Nepomnayshy, MD (SAGES)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):**43235, 43290, 43291

SPECIALTY SOCIETY(IES): ACG, AGA, ASGE, SAGES

PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE), Sheth Ketan, MD (SAGES), Dmitry Nepomnayshy, MD (SAGES)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	000
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
43235	A 67-year-old patient with dyspepsia and weight loss refractory to pharmacological therapy is referred for diagnostic esophagogastroduodenoscopy (EGD) and collection of specimens by brushings.
43290	A 45-year-old female with a body mass index (BMI) of 33 who has failed to respond to dietary and pharmacologic interventions for weight loss undergoes endoscopically guided insertion of a gastric balloon.
43291	A 45-year-old female who is six months post placement of an intragastric balloon presents for removal of the balloon.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The ACG, AGA, ASGE and SAGES convened an RVS expert panel of the surveying specialty societies to review practice expense data for codes 43235, 43290 and 43291. The panel included both sub-specialists and generalists from within the specialties of a variety of settings across the United States. They also received input from practice managers and clinical staff familiar with the direct expense inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The reference code for comparison of 43235 is 43235 with current PE inputs.

   The reference code for comparison of 43290 is 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire*). Code 43226 was selected because it includes an upper endoscopy and passage of the intra-gastric balloon is similar to passing a bougie (43226) with similar clinical staff activities.

   As noted in the Tab 8 PE Excel spreadsheet, CMS recorded 93 minutes of total service period clinical staff time for CPT code 43226, but all materials from the original submission indicate it should be 83

minutes. Neither we nor RUC staff could locate where the extra ten minutes were allocated. They were not in our original recommendations or the RUC's recommendations to CMS. We believe the 93 minutes was a typo in the CMS database when it was originally updated in 2014. We were advised by RUC staff that we must use the 93 minutes currently reflected in the CMS database and that we should use standards to fill in and/or whatever makes sense to the specialty in allocation. We wanted to note this as the PE Subcommittee and the RUC review the time inputs in column M for comparison code 43226 in the PE spreadsheet. Please see the notes in cells M10, M33, M35, M37, and M40 of the RUC Practice Expense Spreadsheet excel file for Tab 8. They are also listed below:

Cell M10 (Total Service Period Clinical Staff Time) note: CMS has 93 min, but all materials from the original submission indicate it should be 83 minutes. Neither we nor RUC staff could locate where the extra ten minutes were allocated. They were not in our original recommendations or the RUC's recommendations to CMS. We believe the 93 minutes was a typo in the CMS database when it was originally updated in 2014. We were advised by RUC staff to use standards to fill in and/or whatever makes sense to the specialty in allocation, which is what is reflected here in column M.

Cell M33 (CA009) note: The recommendation from the RUC to CMS listed 3 minutes, but we increased it to 5 minutes to count toward the 93 minutes of total service period clinical staff time recorded by CMS.

Cell M35 (CA011) note: The recommendation from the RUC to CMS listed 3 minutes, but we increased it to 5 minutes to count toward the 93 minutes of total service period clinical staff time recorded by CMS.

Cell M37 (CA013) note: The recommendation from the RUC to CMS listed 2 minutes, but we increased it to 5 minutes to count toward the 93 minutes of total service period clinical staff time recorded by CMS.

Cell M40 (CA016) note: The recommendation from the RUC to CMS listed 2 minutes, but we increased it to 5 minutes to count toward the 93 minutes of total service period clinical staff time recorded by CMS.

The reference code for comparison of 43291 is 43215 (*Esophagoscopy, flexible, transoral; with removal of foreign body(s)*). Code 43215 was selected because it is most similar to removal of intragastric bariatric balloon(s).

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

43235 is not typically reported with an E/M service. According to the RUC database, 43235 was billed 1.0% of the time with office E/M. It is not typically reported with an E/M service in the non-facility. According to the RUC database, 43235 was billed 7.0% of the time with non-facility office E/M.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Codes 43290 and 43291 are new CPT codes, so there is no data available for them in the RUC database. However, we do not expect these codes to be typically reported with an E/M service or with an E/M service in the non-facility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

For 43235, the dominant provider in the non-facility is Gastroenterology. The percentage of the time gastroenterologists provide 43235 in the non-facility is 77%. The dominant provider in the non-facility is the same as for the global.

Codes 43290 and 43291 are new CPT codes and do not have data available in the RUC database. However, we expect that gastroenterologists will be the dominant provider in the non-facility.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Below is a table showing the current **pre-service** standards and our recommendations for reference.

		Approved by PE Subcmte in Oct. 2012		GI/SAGES Recommendations		
		Non Facility	Non Facility	43235	43X21	43X22
Activity Code	Description of Pre-service Clinical Activities - 000 and 010	Use of clinical staff	Extensive use of clinical staff	EGD base code	Balloon insertion	Balloon removal
CA001	Complete pre-service diagnostic and referral forms	0	5	3	5	3
CA002	Coordinate pre-surgery services (including test results)	0	3	3	3	3
CA003	Schedule space and equipment in facility	0	0	0	0	0
CA004	Provide pre-service education/obtain consent	0	7	0	0	0
CA005	Complete pre-procedure phone calls and prescription	0	3	3	3	3
	Other clinical activity	0	0	0	0	0
	TOTAL	**0**	**18**	**9**	**11**	**9**

43235 Pre-Service Clinical Labor Activities = RN/LPN/MTA
We are not recommending any additional minutes beyond the PE Subcommittee Standards for codes requiring "Extensive use of clinical staff" in the Non-Facility setting.

43235 Intra-Service Clinical Labor Activities = RN/LPN/MTA
We recommend 2 additional minutes above the standards for **CA029** (*Check dressings, catheters, wounds*). Upper GI endoscopy procedures require 3 minutes to perform the following activities: Remove mouthpiece. Retrieve dentures from denture cup and return to patient. Clean patient with towel, place new chux pads (upper and lower) under patient, adjust gown, place patient in a safe position on the endoscopy stretcher, and adjust blanket and/or obtain a new one. Inspect IV sites and IV and supply new bag as needed. Inspect blood pressure cuff for proper position, inspect pulse oximeter on finger to make sure in the right position. Assist anesthesia in patient transport.

CA029 = 3 minutes

43235 Post-Service Clinical Labor Activities = RN/LPN/MTA
We are not recommending any additional minutes beyond the standard for CA037 (*Conduct patient communications*)

***

43290 Pre-Service Clinical Labor Activities = RN/LPN/MTA
We are not recommending any additional minutes beyond the PE Subcommittee Standards for codes requiring "Extensive use of clinical staff" in the Non-Facility setting.

43290 Intra-Service Clinical Labor Activities = RN/LPN/MTA
We recommend 4 additional minutes above the standard for CA011 (*Provide education/obtain consent*). In addition to obtaining consent, staff instructs the patient about the six medications they will take after the procedure to address nausea, vomiting, and pain (i.e., narcotic pain medication, antispasmotic, Scopolamine Patch, Zofran, Phenergan, Ativan) and the schedule for taking the medications to prevent interactions as well as NARCAN and answers the patient's questions about the medications. Staff reviews instructions for NARCAN with the patient and provides counseling for interaction of benzodiazepines and narcotics, which is required by most states. Staff also reviews with patient what to do and avoid doing during the first 24-hours, first 3 days and first week following the procedure (e.g., drink at least 8 cups of liquid per day. Take small sips. Wait a minute or two between sips. Slowly take more with each sip. Drink only 1/3 cup at a time. Sit upright for 3 to 4 hours after drinking.) See p. 13-14 of "Orbera Patient Booklet" https://www.orbera.com/resource/us_orbera_pdfs/pdfs/GRF-00345-00R08.pdf. Staff counsels the patient on expectations for side effects (e.g., side effects to expect, timing of side effects, how long they should last, how to manage them, when to call the office and when to go to the emergency department). Staff also provides counseling on dietary recommendations. Please note that we have not included any minutes for education/consent activities in CA004 so there is no overlap or duplication. **CA011 = 15 minutes**

We recommend 3 minutes above the standard for CA013 (*Prepare room, equipment and supplies*). Staff must verify the implant is not expired and all required components are in the kit. Staff must assemble the kit prior to beginning the procedure, including preparing the syringes, IV line tubing, saline bag, etc.
CA013 = 5 minutes

We recommend 2 additional minutes above the standards for **CA029** (*Check dressings, catheters, wounds*). Upper GI endoscopy procedures require 3 minutes to perform the following activities: Remove mouthpiece. Retrieve dentures from denture cup and return to patient. Clean patient with towel, place new chux pads (upper and lower) under patient, adjust gown, place patient in a safe position on the endoscopy stretcher, and adjust blanket and/or obtain a new one. Inspect IV sites and IV and supply new bag as needed. Inspect blood pressure cuff for proper position, inspect pulse oximeter on finger to make sure in the right position. Assist anesthesia in patient transport.
CA029 = 3 minutes

43290 Post-Service Clinical Labor Activities = RN/LPN/MTA

We are not recommending any additional minutes beyond the standard for CA037 (*Conduct patient communications*).

***

43291 Pre-Service Clinical Labor Activities = RN/LPN/MTA
We are not recommending any additional minutes beyond the PE Subcommittee Standards for codes requiring "Extensive use of clinical staff" in the Non-Facility setting.

43291 Intra-Service Clinical Labor Activities = RN/LPN/MTA
We recommend 3 minutes above the standard for CA013 (*Prepare room, equipment and supplies*). Staff must assemble and set up the tubing and the equipment to extract the fluids from the balloon(s) and prepare multiple syringes for extraction.
CA013 = 5 minutes

We recommend 2 additional minutes above the standard for CA011 (*Provide education/obtain consent*). In addition to obtaining consent, staff must provide post procedure dietary recommendations and counseling, including information on change of patient's sense of satiety and appropriate diet to manage those changes. Please note that we have not included any minutes for education/consent activities in CA004 so there is no overlap or duplication. **CA011 = 5 minutes**

We recommend 8 minutes above the standard for CA016 (*Prepare, set-up and start IV, initial positioning and monitoring of patient*). Patient is intubated while supine and staff must move the patient into left lateral position. Positioning the patient for balloon removal is identical to ERCP (43260 family) which has 10 minutes for positioning the patient. **CA016 = 10 minutes**

We recommend 2 additional minutes above the standards for **CA029** (*Check dressings, catheters, wounds*). Upper GI endoscopy procedures require 3 minutes to perform the following activities: Remove mouthpiece. Retrieve dentures from denture cup and return to patient. Clean patient with towel, place new chux pads (upper and lower) under patient, adjust gown, place patient in a safe position on the endoscopy stretcher, and adjust blanket and/or obtain a new one. Inspect IV sites and IV and supply new bag as needed. Inspect blood pressure cuff for proper position, inspect pulse oximeter on finger to make sure in the right position. Assist anesthesia in patient transport.
CA029 = 3 minutes

43291 Post-Service Clinical Labor Activities = RN/LPN/MTA
We are not recommending any additional minutes beyond the standard for CA037 (*Conduct patient communications*).

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

CMS allocated 5 minutes to clinical activity CA010 (*obtain vital signs*) for code 43235 prior to CMS increasing the clinical activity to 5 minutes for CY 2018.

For codes 43235, 43290 and 43291, at least 4 vital signs are taken prior to beginning the procedure to ensure the patient is healthy enough to undergo the procedures. Vital signs taken prior to the procedure include patient's temperature, heart rate, respiratory rate, and blood pressure and may include additional vital signs.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

43235 and 43291 Pre-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to complete pre-service diagnostic and referral forms (CA001)
- 3 minutes to coordinate pre-surgery services (including test results) (CA002)
- 3 minutes to complete pre-procedure phone calls and prescription (CA005)

43290 Pre-Service Clinical Labor Activities = RN/LPN/MTA
- 5 minutes to complete pre-service diagnostic and referral forms (CA001)
- 3 minutes to coordinate pre-surgery services (including test results) (CA002)
- 3 minutes to complete pre-procedure phone calls and prescriptions (CA005)

   b. Service period (includes pre, intra and post):

43235 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to greet patient, provide gowning, ensure appropriate medical records are available (CA009)
- 5 minutes to obtain vital signs (CA010)
- 3 minutes to provide education/obtain consent (CA011)
- 2 minutes to prepare room, equipment and supplies (CA013)
- 5 minutes to setup scope (nonfacility setting only) (CA015)
- 2 minutes to prepare, set-up and start IV, initial positioning and monitoring of patient (CA016)
- 15 minutes to assist physician or other qualified healthcare professional---directly related to physician work time (100%) (CA018)
- 3 minutes to clean room/equipment by clinical staff (CA024)
- 30 minutes to clean scope (CA025)
- 2 minutes to complete post-procedure diagnostic forms, lab and x-ray requisitions (CA027)
- 3 minutes to check dressings, catheters, wounds (CA029)

43290 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to greet patient, provide gowning, ensure appropriate medical records are available (CA009)

- 5 minutes to obtain vital signs (CA010)
- 15 minutes to provide education/obtain consent (CA011)
- 5 minutes to prepare room, equipment and supplies (CA013)
- 5 minutes to setup scope (nonfacility setting only) (CA015)
- 2 minutes to prepare, set-up and start IV, initial positioning and monitoring of patient (CA016)
- 30 minutes to assist physician or other qualified healthcare professional---directly related to physician work time (100%) (CA018)
- 3 minutes to clean room/equipment by clinical staff (CA024)
- 30 minutes to clean scope (CA025)
- 2 minutes to complete post-procedure diagnostic forms, lab and x-ray requisitions (CA027)
- 3 minutes to check dressings, catheters, wounds (CA029)
- 2 minutes to review home care instructions, coordinate visits/prescriptions (CA035)

43291 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to greet patient, provide gowning, ensure appropriate medical records are available (CA009)
- 5 minutes to obtain vital signs (CA010)
- 5 minutes to provide education/obtain consent (CA011)
- 5 minutes to prepare room, equipment and supplies (CA013)
- 5 minutes to setup scope (nonfacility setting only) (CA015)
- 10 minutes to prepare, set-up and start IV, initial positioning and monitoring of patient (CA016)
- 30 minutes to assist physician or other qualified healthcare professional---directly related to physician work time (100%) (CA018)
- 3 minutes to clean room/equipment by clinical staff (CA024)
- 30 minutes to clean scope (CA025)
- 2 minutes to complete post-procedure diagnostic forms, lab and x-ray requisitions (CA027)
- 3 minutes to check dressings, catheters, wounds (CA029)

c. Post-service period:

43235, 43290 and 43291 Post-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to conduct patient communications (CA037)

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

43235 Intra-service (of service period) = RN/LPN/MTA
Clinical staff assists the physician with the procedure for 100% of the intra-service procedure time. The clinical staff assists with technical procedural-related activities such as collecting specimens.

43290 Intra-service (of service period) = RN/LPN/MTA
Clinical staff assists the physician with the procedure for 100% of the intra-service procedure time. Staff assist with technical procedural-related activities during balloon placement such as adding methylene blue to the saline and drawing the fluid up into syringes in preparation for the physician to fill the balloon.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

43291 Intra-service (of service period) = RN/LPN/MTA
Clinical staff assists the physician with the procedure for 100% of the intra-service procedure time. Staff assist with technical procedural-related activities during balloon deflation and removal such as assisting in attaching the needle to suction the fluid to deflate the balloon.

11. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
We have submitted 8 paid invoices provided by Apollo which have been catalogued in the Excel file titled "Tab 8 – invoice summary_43290_43291." These invoices contain prices for the ORBERA Intragastric Balloon System (balloon, placement catheter and connection tube with 3-way valve and saline bag spike) to place the device and the needle aspirator & grasper to remove the device.

17. Are you recommending a PE supply pack for this recommendation? **Yes** or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
We are recommending SA042 (*pack, cleaning and disinfecting, endoscope*) and SA048 (*pack, minimum multi-specialty visit*) which are defined by CMS and commercially available.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Pack, cleaning and disinfecting, endoscope (SA042) item, 1 ($18.838)
gloves, non-sterile (SB022) pair, 4 ($0.246)
gown, staff, impervious (SB027) item, 1 ($1.186)
face shield, splash protection (SB034) item, 1 ($3.40)
biohazard bag (SM008) item, 1 ($0.0688)
gauze, sterile 4in x 4in (10 pack uou) (SG056) item, 1 ($1.0995)
alcohol isopropyl 70% (SJ001) ml, 60 ($0.023)
cleaning brush, endoscope (SM010) item, 1 ($3.6105)
glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide) (SM018) oz, 32 ($2.6212)
glutaraldehyde test strips (Cidex, Metrex) (SM019) item, 1 ($0.883)

Pack, minimum multi-specialty visit (SA048) item, 1 ($4.0507)
Patient gown, disposable (SB026) item, 1
Exam table paper (SB036) feet, 7
Pillowcase, disposable (SB037) item, 1
Gloves, non-sterile (SB022) pair, 2
Thermometer probe cover, disposable (SB004) item, 1

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ235 (Suction machine, Gomco) = Scope systems formula
CA013 + CA014 + CA015 + CA016 + CA017 + CA018 + CA019 + CA020 + CA024

ES031 (scope video system (monitor, processor, digital capture, cart, printer, LED light)) = scope systems formula
CA013 + CA014 + CA015 + CA016 + CA017 + CA018 + CA019 + CA020 + CA024

ES087 (multi-channeled flexible digital scope, esophagoscopy gastroscopy duodenoscopy (EGD)) = Scope formula
CA013 + CA014 + CA015 + CA016 + CA017 + CA018 + CA019 + CA020 + CA025

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ES005 (endoscope disinfector, rigid or fiberoptic, w-cart) = Other formula*
CA025
*The time for the endoscope disinfector equals CA025 (Clean scope)

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

NA

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A – Codes 43235, 43290 and 43291 are not PE only codes.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N	Q	R	S	T	W	X
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**43235**		**43235**		**43226**		**43290**		**43215**		**43291**	
3		***RUC Collaboration Website***				Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)		Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)		Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire **Please see the notes in column M**		Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon		Esophagoscopy, flexible, transoral; with removal of foreign body(s)		Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable): 4/12/2021** **Tab: 8 (Endoscopic Bariatric Device Procedures)** **Specialty: ACG, AGA, ASGE, SAGES**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**												
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 145.17**	**$ 8.14**	**$ 138.68**	**$ 8.14**	**$ 211.54**	**$ 8.14**	**$ 2,015.02**	**$ 8.14**	**$ 209.97**	**$ 8.14**	**$ 261.02**	**$ 8.14**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**85.0**	**22.0**	**85.0**	**22.0**	**105.0**	**22.0**	**119.0**	**22.0**	**90.0**	**22.0**	**113.0**	**22.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**9.0**	**19.0**	**9.0**	**19.0**	**9.0**	**19.0**	**11.0**	**19.0**	**9.0**	**19.0**	**9.0**	**19.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**73.0**	**0.0**	**73.0**	**0.0**	**93.0**	**0.0**	**105.0**	**0.0**	**78.0**	**0.0**	**101.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 31.45**	**$ 8.14**	**$ 31.45**	**$ 8.14**	**$ 38.85**	**$ 8.14**	**$ 44.03**	**$ 8.14**	**$ 33.30**	**$ 8.14**	**$ 41.81**	**$ 8.14**
13		**PRE-SERVICE PERIOD**															
14		**Start: Following visit when decision for surgery/procedure made**															
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	3	3	3	3	3	3	5	3	3	3	3	3
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	3	5	3	5	3	5	3	5	3	5	3	5
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		3		3		3		3		3		3
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		5		5		5		5		5		5
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	3	3	3	3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37												
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37												
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37												
23			L037D	RN/LPN/MTA	0.37												
26		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37												
29		**End: When patient enters office/facility for surgery/procedure**															
30		**SERVICE PERIOD**															
31		**Start: When patient enters office/facility for surgery/procedure:**															
32		**Pre-Service (of service period)**															
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37	3		3		5		3		3		3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5		5		5		5		5	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37	3		3		5		15		3		5	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37												
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2		5		5		2		5	
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37												
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37	5		5		5		5		5		5	
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2		2		5		2		2		10	
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37												
42			L037D	RN/LPN/MTA	0.37												
45		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37												
48		**Intra-service (of service period)**															
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37	15		15		25		30		20		30	
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37												
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37												
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37												
55			L037D	RN/LPN/MTA	0.37												
56		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37												
59		**Post-Service (of service period)**															
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37												
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37												
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3		3		3		3		3	
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37	30		30		30		30		30		30	
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37												
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37	2		2		2		2		2		2	
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37												
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	3		3		3		3		3		3	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37												
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37												
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37												
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37												
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs,	L037D	RN/LPN/MTA	0.37												
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37							2					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37												
78		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37												
81		**End: Patient leaves office/facility**															
82		**POST-SERVICE PERIOD**															
83		**Start: Patient leaves office/facility**															
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3	3	3	3	3	3	3	3	3	3	3	3
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37												
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16														
88		99212 27 minutes	27														
89		99213 36 minutes	36														
90		99214 53 minutes	53														
91		99215 63 minutes	63														
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37												
96		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37												
99		**End: with last office visit before end of global period**															

	A	B	D	E	F	I	J	K	L	M	N	Q	R	S	T	W	X
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		REFERENCE CODE		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2						43235		43235		43226		43290		43215		43291	
3		*RUC Collaboration Website*				Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)		Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)		Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire **Please see the notes in column M**		Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon		Esophagoscopy, flexible, transoral; with removal of foreign body(s)		Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	
4	Clinical Activity Code	Meeting Date: April 2021 Revision Date (if applicable): 4/12/2021 Tab: 8 (Endoscopic Bariatric Device Procedures) Specialty: ACG, AGA, ASGE, SAGES	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute												
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				000	000	000	000	000	000	000	000	000	000	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 145.17	$ 8.14	$ 138.68	$ 8.14	$ 211.54	$ 8.14	$ 2,015.02	$ 8.14	$ 209.97	$ 8.14	$ 261.02	$ 8.14
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	85.0	22.0	85.0	22.0	105.0	22.0	119.0	22.0	90.0	22.0	113.0	22.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	9.0	19.0	9.0	19.0	9.0	19.0	11.0	19.0	9.0	19.0	9.0	19.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	73.0	0.0	73.0	0.0	93.0	0.0	105.0	0.0	78.0	0.0	101.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
100	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT													
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ 88.38	$ -	$ 88.38	$ -	$ 139.12	$ -	$ 1,944.85	$ -	$ 149.31	$ -	$ 189.82	$ -
102	SA042	pack, cleaning and disinfecting, endoscope	18.838	pack		1		1		1		1		1		1	
103	SA043	pack, cleaning, surgical instruments	10.7922	pack						1							
104	SA048	pack, minimum multi-specialty visit	4.0507	pack		1		1		1		1		1		1	
105	SB001	cap, surgical	0.9072	item		3		3		3		3		3		3	
106	SB006	drape, non-sterile, sheet 40in x 60in	0.153	item		1		1		1		1		1		1	
107	SB027	gown, staff, impervious	1.186	item		2		2		2		2		2		2	
108	SB034	mask, surgical, with face shield	3.4	item		3		3		3		3		3		3	
109	SB039	shoe covers, surgical	0.1595	pair		3		3		3		3		3		3	
110	SC056	syringe 50-60ml	1.0677	item		1		1		1		1		1		1	
111	SD006	bite block	2.325	item		1		1		1		1		1		1	
112	SD009	canister, suction	4.2095	item		1		1		1		1		1		2	
113	SD067	endoscopic cytology brush	16.7875	item		1		1		1		1		1		1	
114	SD068	endoscopic polypectomy snare	26.1875	item										1			
115	SD070	endosheath	15.7725	item										1			
116	SD090	guidewire, STIFF	39.9425	item						1							
117	SD132	tubing, suction, non-latex (6ft uou)	0.9212	item		1		1		1		1		1		2	
118	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	2.7428	item		1		1		1		1		1		2	
119	SD289	PROXY endoscopic grasping forceps	18.9725	item										1			
120	SG051	gauze, non-sterile 4in x 4in	0.0312	item		1		1		1		1		1		1	
121	SH067	sodium chloride 0.9% inj (250-1000ml uou)	2.9695	item		1		1		1		2		1		1	
122	SJ010	basin, emesis	0.2415	item		1		1		1		1		1		1	
123	SJ016	denture cup	0.2707	item		1		1		1				1			
124	SJ032	lubricating jelly (K-Y) (5gm uou)	0.4215	item		4		4		4		8		4		4	
125	SK058	paper, photo printing (8.5 x 11)	0.7125	item		1		1		1		1		1		1	
126	SL035	cup, biopsy-specimen non-sterile 4oz	0.1643	item		1		1		1		0		1		0	
127	SM014	endoscope anti-fog solution	0.8367	ml		1		1		1		1		1		1	
128	SM023	scrub brush (impregnated)	4.8673	item		3		3		3		3		3		3	
129	SL250	methylene blue stain	0.2245	ml								10					
130	NEW	ORBERA Intragastric Balloon System (balloon, placement catheter and connection tube with 3-way valve and saline bag spike)	1850	item								1					
131	NEW	Needle aspirator and grasper	94	item												1	
134	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute												
135		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ 25.33	$ -	$ 18.85	$ -	$ 33.58	$ -	$ 26.14	$ -	$ 27.36	$ -	$ 29.39	$ -
136	EQ235	suction machine (Gomco)	1981.664	Scope Systems	0.005258794	43		27		63		45		48		53	
137	ES005	endoscope disinfector, rigid or fiberoptic, w-cart	27500	Other Formula	0.086369514	30		30		30		30		30		30	
138	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)	53489.691	Scope Systems	0.202673463	43		27		63		45		48		53	
139	ES087	multi-channeled flexible digital scope, esophagoscopy gastroscopy duodenoscopy (EGD)	34585.35	Scope	0.197171404	70		54				72				80	
140	ES088	multi-channeled flexible digital scope, esophagoscopy	34585.35	Scope	0.197171404					90				75			
141	EQ137	instrument pack, basic ($500-$1499)	500	Default	0.002323783					60							
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*															

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly*

April 2021

Anterior Abdominal Hernia Repair – Tab 9

CPT Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC as a service performed less than 50% of the time in the inpatient setting, included inpatient hospital E/M service codes and had Medicare utilization over 5,000. The stakeholder societies requested referral to CPT to update the descriptor of 49565 and other abdominal hernia codes to better describe these procedures as performed in current practice. As a result of the disparate site of service for anterior abdominal hernia repair codes, new codes were established and a 000-day global period was recommended. In addition, new codes for parastomal hernia repair, an add-on code to report removal of total or near total mesh, and a new code for placement of delayed mesh closure were established. The specialty societies collected data on typical site-of-service, hospital stays and associated Evaluation and Management (E/M) visits for the new codes through the survey process.

The specialty societies described the differences between the services included in this code family and explained that these CPT codes are generally differentiated by three factors: 1) whether the hernia is initial or recurrent; 2) whether the hernia is reducible or incarcerated/ strangulated; and 3) the total length of the hernia defect (< 3cm, 3-10cm, or > 10cm in length). Furthermore, two new codes were established to report parastomal hernia repair, which involves the repair of a hernia proximal to a pre-existing stoma. The specialty societies noted that each of these three factors impacts the work involved in a hernia repair. The repair of an incarcerated/strangulated hernia involves more work than that of a reducible hernia; the repair of a larger hernia involves more work than that of a smaller hernia; and the repair of a recurrent hernia requires more work than repair of an initial hernia. This is illustrated by the fact that CPT code 49591 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible* (recommended work RVU = 6.27, 45 minutes of intra-service time, 108 minutes of total time) has the lowest recommended work RVU of this code family and CPT code 49618 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated* (recommended work RVU = 24.00, 180 minutes of intra-service time, 335 minutes of total time) has the highest recommended work RVU of this code family. In reviewing this code family, the RUC noted the importance of work RVU recommendations for individual codes and maintaining relativity across the entire code family (as shown in Table 1 below). The specialty societies noted – and the RUC concurred – that there is a dearth of available comparator codes for 000-day global codes with similar work RVUs and intra-service and total times for such major procedures and that this makes it particularly important to consider and maintain relativity within this code family.

The RUC acknowledged that the construction of the CPT codes in this family appropriately address the reporting of incarcerated/strangulated hernias. The introductory language for this code family states, "When both reducible and incarcerated/strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated/strangulated. For example, one 2 cm reducible initial incisional hernia and one 4 cm incarcerated initial incisional hernias separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudad distance of 8 cm (49594)." As stated by the specialties, hernias of this sort are all generally the same piece of bowel

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herniating through the midline anterior abdominal wall defect and are not repaired separately; they are all the same hernia and if the interspace of the fascia were not intact (even for 1 cm), the entire single bulge would be considered incarcerated/strangulated. According to the specialty societies, it is also rare that if there are multiple hernias in the same proximity, there would be a separate hernia that is reducible and a separate hernia that is incarcerated/strangulated; it is most common that all the hernias would be incarcerated/strangulated as part of the same segment of bowel. Furthermore, in the scenario outlined in the CPT introductory language, if the 2 cm initial hernia (reducible) and the 4 cm initial hernia (incarcerated/strangulated) were separated and reported as 49591 and 49594 with April 2021 RUC recommended work RVUs, the total work RVU value would be **greater** (total work RVUs recommended = 20.27 for 49591 **and** 49594) than for just reporting the service as 49594 (recommended work RVU = 14.00). This would also be the case if the incarcerated/strangulated hernia were less than 3 cm in length and reported as 49592 (total work RVUs recommended = 15.27 for 49591 **and** 49592).

Table 1: Anterior Abdominal Hernia Repair: Work RVU Recommendations

CPT Code	DESC	Recommended Work RVU
49591	**Initial,** Reduc, < 3cm	**6.27**
49613	**Recurrent,** Reduc, < 3cm	**7.75**
49592	**Initial, I/S,** < 3cm	**9.00**
49614	**Recurrent, I/S,** < 3cm	**10.79**
49593	**Initial,** Reduc, 3-10cm	**10.80**
49615	**Recurrent,** Reduc, 3-10cm	**12.00**
49621	**Parastomal**, Reduc	**14.24**
49594	**Initial, I/S,** 3-10cm	**14.00**
49595	**Initial,** Reduc, > 10cm	**14.88**
49616	**Recurrent, I/S,** 3-10cm	**16.50**
49617	**Recurrent,** Reduc, > 10cm	**16.97**
49622	**Parastomal**, **I/S**	**18.00**

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49596	**Initial, I/S,** > 10cm	**20.00**
49618	**Recurrent, I/S, > 10cm**	**24.00**
+49623	Removal of total or near-total non-infected mesh	**5.00**

Table 2: Mesh for Delayed Closure of Defect(s): Work RVU Recommendations		
CPT Code	**DESC**	**Recommended Work RVU**
15778	Implantation of absorbable mesh or other prosthesis	**8.00**

Initial Abdominal Hernia Repair

49591 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible***
The RUC reviewed the survey results from 39 surgeons for CPT code 49591 and determined that the survey 25th percentile work RVU of 6.27 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 20 minutes of immediate post-service time, and 108 minutes of total time. The specialty societies noted that this service involves the repair of the smallest type of an initial reducible hernia.

The typical patient is discharged on the same day and therefore there are no post-operative same day visits associated with 49591. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted CPT add-on code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 6.27, the RUC compared CPT code 49591 to top key reference service CPT code 31600 *Tracheostomy, planned (separate procedure)* (work RVU = 5.56, 30 minutes of intra-service and 120 minutes of total time) and second key reference service CPT code 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75, 60 minutes of intra-service time and 148 minutes of total time) and noted that the surveyed code is appropriately bracketed by these two services based on the complexity of physician work and intra-service time required to perform these services. The RUC also compared CPT code 49591 to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of*

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calculus (ureteral catheterization is included) (work RVU = 6.75, 45 minutes of intra-service and 118 minutes of total time). The RUC determined that these values support the recommended work RVU and noted that CPT code 49591 requires the same 45 minutes of intra-service time as MPC code 52352 but slightly less total time and support the slightly lower work RVU recommendation. **The RUC recommends a work RVU of 6.27 for CPT code 49591**.

49592 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 39 surgeons for CPT code 49592 and determined that the survey 25th percentile work RVU of 9.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 30 minutes of immediate post-service time, and 143 minutes of total time. The specialty societies noted that the repair of an incarcerated/strangulated hernia requires more intra-service time and is more complex than the repair of a reducible hernia of the same or similar size. In addition, the specialties indicated that the repair of an incarcerated/strangulated hernia is typically performed laparoscopically and typically involves a loop of bowel which must be pulled down through the hernia and could potentially bleed. The high intensity of this service necessitates an overnight stay to monitor the abdomen and particularly the bowel that has been drawn through the hernia. Pain and bowel function is also a significant concern that requires close monitoring.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the survey immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 9.00, the RUC compared CPT code 49592 to CPT code 43276 *Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged* (work RVU = 8.84, 60 minutes of intra-service and 123 minutes of total time) and CPT code 33954 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older* (work RVU = 9.11, 60 minutes intra-service and 178 minutes of total time). The RUC determined that these services include the same intra-service time as the surveyed code and appropriately bracket the recommend work RVU of CPT code 49592. **The RUC recommends a work RVU of 9.00 for CPT code 49592**.

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49593 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, reducible***
The RUC reviewed the survey results from 41 surgeons for CPT code 49593 and determined that the survey 25th percentile work RVU of 10.80 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 30 minutes of immediate post-service time, and 175 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia of this size. The evaluation time was reduced from Pre-time Package 3 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the survey immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 10.80, the RUC compared CPT code 49593 to top key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) as well as MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service and 141 minutes of total time) and noted that the recommended work RVU of 10.80 is appropriately higher than that of MPC code 36906 given 49593's higher total time and is appropriately lower than that of top key reference service 11006 given 49593's lower intra-service and total time. **The RUC recommends a work RVU of 10.80 for CPT code 49593**.

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49594 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 41 surgeons for CPT code 49594 and determined that the survey 25th percentile work RVU of 14.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 40 minutes of immediate post-service time, and 225 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99225/99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 20 minutes for 99225/99232 has been added to the immediate post-service time (total of 40 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 14.00, the RUC compared CPT code 49594 to top key reference service CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes of intra-service and 166 minutes of total time) and noted that these codes bracket CPT code 49594 with appropriate work RVUs and noted that the recommended work RVU of 14.00 is appropriately higher than that of MPC code 37244 given 49594's higher intra-service and total time and is appropriately lower than that of top key reference service 11005 given 49594's lower total time. **The RUC recommends a work RVU of 14.00 for CPT code 49594**.

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49595 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, reducible***
The RUC reviewed the survey results from 40 surgeons for CPT code 49595 and determined that the survey 25th percentile work RVU of 14.88 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 40 minutes of immediate post-service time, and 230 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99225/99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 20 minutes for 99225/99232 has been added to the immediate post-service time (total of 40 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 14.88, the RUC compared CPT code 49595 to second key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and noted that both services require similar physician work and time to perform. The RUC also referenced MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes of intra-service and 166 minutes total time) and noted that 20 percent of survey respondents determined that 49595 is much more complex than second key reference service 11005 and 60 percent of survey respondents determined that 49595 is somewhat more complex than 11005, which supports a slightly higher work RVU value for 49595. The higher recommended intra-service and total time for 49595 supports a higher work RVU value than 37244. **The RUC recommends a work RVU of 14.88 for CPT code 49595**.

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49596 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 40 surgeons for CPT code 49596 and determined that the survey median work RVU of 20.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 160 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99233 post-operative observation visit, and 310 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the at the level of 99233 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant postoperative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 20.00, the RUC compared CPT code 49596 to top key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and second key reference service 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* (work RVU = 20.12, 232 minutes of intra-service and 362 minutes of total time) and noted that the recommended intra-service and total times support a work RVU higher than that of top key reference service 11005. The RUC also noted that 44 percent of survey respondents determined that 49596 is much more complex than second key reference service 61624 and 44 percent of survey respondents determined that 49596 is somewhat more complex than 61624, supporting a slightly lower work RVU despite the differences in intra-service and total time. **The RUC recommends a work RVU of 20.00 for CPT code 49596.**

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Recurrent Abdominal Hernia Repair

49613 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible***
The RUC reviewed the survey results from 41 surgeons for CPT code 49613 and determined that the survey 25th percentile work RVU of 7.75 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 20 minutes of immediate post-service time, and 135 minutes of total time. The RUC noted that this service involves the repair of the smallest size of a *recurrent* hernia and that there would be additional time and intensity associated with this service over CPT code 49591 because of the previous procedure. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen. The evaluation time was reduced from Pre-time Package 3 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The typical patient is discharged on the same day and therefore there are no post-operative visits associated with 49613. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 7.75, the RUC compared CPT code 49613 to CPT code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 7.55, 45 minutes of intra-service and 135 minutes of total time), CPT code 52240 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; large bladder tumor(s)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and noted that the work RVUs, intra-service times and total times in this range of codes supports the work RVU recommendation for CPT code 49613 and that the added work associated with a recurrent hernia with respect to a reducible hernia places the recommended work RVU within appropriate rank order in this code family. **The RUC recommends a work RVU of 7.75 for CPT code 49613**.

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49614 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 41 surgeons for CPT code 49614 and determined that the survey 25th percentile work RVU of 10.79 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 75 minutes of intra-service time, 30 minutes of immediate post-service time, and 165 minutes of total time. The specialty societies specified that this service involves a recurrent hernia (as opposed to an initial hernia) and that involves another opening adjacent to the previously placed mesh and scar tissue and that the service is typically performed laparoscopically and involves working around a piece of incarcerated/strangulated bowel. These factors increase the time and intensity involved in performing the service. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the immediate post-service time (total of 30 minutes). The RUC noted that the recommended work RVU of 10.79 places this code in appropriate rank order within this code family with respect to overall intensity. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection(List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 10.79, the RUC compared CPT code 49614 to top key reference service CPT code 21811 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs* (work RVU = 10.79, 120 minutes of intra-service and 220 minutes of total time) and noted that the surveyed code requires less intra-service time but is much more intense, thus appropriate to be valued the same. Of the respondents who chose 21811 as the key reference service, 67% indicated CPT code 49614 requires more mental effort, technical skill and physician stress than CPT code 21811.

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For additional support, the RUC referenced MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes of intra-service and 141 minutes of total time). **The RUC recommends a work RVU of 10.79 for CPT code 49614**.

49615 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, reducible***
The RUC reviewed the survey results from 43 surgeons for CPT code 49615 and determined that the survey 25th percentile work RVU of 12.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 100 minutes of intra-service time, 30 minutes of immediate post-service time, and 190 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

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To support a work RVU of 12.00, the RUC compared CPT code 49615 to top key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) and second key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time), both which require more physician work and time than 49615; thus it is appropriately valued slightly lower. **The RUC recommends a work RVU of 12.00 for CPT code 49615**.

49616 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 43 surgeons for CPT code 49616 and determined that the survey 25th percentile work RVU of 16.50 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 140 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 275 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

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To support a work RVU of 16.50, the RUC compared CPT code 49616 to top key reference service 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU = 20.00, 173 minutes of intra-service time and 323 minutes of total time) and the second key reference service 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that the surveyed code requires less physician time and work; thus it is appropriately valued lower.

For additional support, the RUC referenced MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes of intra-service and 166 minutes of total time) and noted that the surveyed code requires more physician work and time to perform, thus is valued higher. **The RUC recommends a work RVU of 16.50 for CPT code 49616**.

49617 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, reducible***
The RUC reviewed the survey results from 42 surgeons for CPT code 49617 and noted that the survey 25th percentile work RVU recommendation would have created a rank order anomaly within the recommended work RVU values across this code family. The specialty societies noted that while the hernia repair associated with CPT code 49616 involves an incarcerated/strangulated hernia, the hernia repair associated with CPT code 49617 involves a significantly larger area of repair and involves multiple hernias in a line. However, the RUC determined that the survey median work RVU value of 18.53 overvalues the work associated with performing this procedure. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC determined that a direct work RVU crosswalk to CPT code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU = 16.97, 150 minutes of intra-service and 210 minutes of total time) appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 28 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 288 minutes of total time for CPT code 49617.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family;
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communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. The insertion of mesh or other prosthesis is bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 16.97, the RUC compared CPT code 49617 to second key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) and top key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and noted that the higher intra-service time and the complexity associated with the repair of a recurrent abdominal hernia greater than 10 cm in length supports a higher work RVU than the key reference services. **The RUC recommends a work RVU of 16.97 for CPT code 49617**.

49618 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 42 surgeons for CPT code 49618 and determined that the survey median work RVU of 24.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 335 minutes of total time. The specialty noted that the hernia repair associated with this service involves a large and recurrent hernia which presents several challenges, including navigating previous repairs (including scar tissue and previously placed mesh) and addressing the piece of bowel that is incarcerated or strangulated.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99233 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant postoperative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions. The insertion of mesh or other prosthesis is bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

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To support a work RVU of 24.00, the RUC compared CPT code 49618 to top key reference service CPT code 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* (work RVU = 20.12, 232 minutes of intra-service and 362 minutes of total time) and second key reference service CPT code 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that the work associated with 49618 is significantly more complex given the size, recurrence, and incarceration/strangulation and that this service is the most complex in the rank order of this code family. **The RUC recommends a work RVU of 24.00 for CPT code 49618.**

Parastomal Hernia Repair

49621 ***Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible***

The RUC reviewed the survey results from 39 surgeons for CPT code 49621 and determined that the specialty recommended survey median work RVU of 15.50 overvalues the work associated with this service. However, the RUC determined that the survey 25th percentile work RVU of 13.50 undervalues the work associated with this service and would create a rank order anomaly within this code family.

The RUC determined that a direct work RVU crosswalk to CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) appropriately reflects the relative work required to perform this service and places CPT code 49621 in appropriate rank order within this family of anterior abdominal hernia repair codes. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99231 post-operative observation visit, and 235 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later of the same date at the level of 99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported

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changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family.. The RUC noted that the parastomal abdominal hernia occurs proximal to a pre-existing stoma and colostomy and requires the maintenance of an abdominal defect to maintain the colostomy and that these factors make it a more complex service than a typical reducible abdominal hernia repair.

To support a work RVU of 14.24, the RUC compared CPT code 49621 to CPT code 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 14.75, 135 minutes intra-service time and 203 minutes of total time) and determined that the work RVU of 14.75 is appropriately higher than the recommended work RVU of 14.24 for 49621. **The RUC recommends a work RVU of 14.24 for CPT code 49621**.

49622 ***Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; incarcerated or strangulated***

The RUC reviewed the survey results from 39 surgeons for CPT code 49622 and determined that the survey median work RVU of 18.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 285 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later on the same date at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family.. The RUC noted that the parastomal abdominal hernia occurs proximal to a pre-existing stoma and colostomy and requires the maintenance of an abdominal defect to maintain the colostomy and that these factors make it a more complex service than a typical reducible abdominal hernia repair. The incarcerated/strangulated piece of bowel necessarily requires more work for 49622 than that associated with repair of a reducible parastomal hernia for 49621.

To support a work RVU of 18.00, the RUC compared CPT code 49622 to top key reference service CPT code 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that of the survey respondents who chose 21813 as the key reference service,

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100% indicated that the surveyed code was more intense and complex on all measures. Therefore, although the surveyed code requires slightly less intra-service time than CPT code 21813, it is appropriate that it is valued slightly higher since it is more intense and complex. The RUC compared 49622 to the second key reference service CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU = 20.00, 173 minutes of intra-service and 323 minutes of total time) and noted that 49622 requires less physician work and time, thus is valued appropriately slightly lower than 33891. The RUC noted that 49622 is valued appropriately higher than 49621 given the piece of incarcerated/strangulated bowel associated with 49622. **The RUC recommends a work RVU of 18.00 for CPT code 49622**.

Removal of Mesh or Other Prosthesis

49623 ***Removal of total or near-total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)***The RUC discussed the subject of mesh implantation and removal at length. The specialties indicated that when add-on CPT code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the February 2021 CCA. However, the specialties also informed the RUC that mesh removal is not always required and is not typical. Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed. The RUC was concerned that the code descriptor may be reported no matter how much mesh is removed, including minimal trimming. The specialty societies explained that the purpose of CPT code 49623 is not to report mesh trimming or adjustment but the total or near total removal of mesh. The specialty society noted that this code should be rarely used as the total or near total removal of mesh is extremely invasive and damaging. **The specialty societies recommended - and the RUC agreed - to refer this issue to the CPT Panel to editorially revise the CPT guidelines for the Anterior Abdominal Hernia Repair subsection to specify "total or near total" mesh removal and revise the code descriptor for CPT code 49623 to specify "total or near total non-infected" mesh removal.**

The RUC reviewed the survey results from 150 surgeons for CPT code 49623 and determined that the survey median and 25th percentile work RVU of 5.00 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and total time.

To support a work RVU of 5.00, the RUC compared CPT code 49623 to the top key reference service 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)* (work RVU = 5.00, 60 minutes of intra-service and total time), the second key reference service CPT code 35572 *Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)* (work RVU = 6.81, 60 minutes of intra-service and total time) and

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noted that the survey respondents indicated the intensity and complexity of CPT code 49623 was greater that both CPT code 11008 and CPT code 35572. Both of the reference codes are performed via an open approach with direct visualization, while 49623 will typically be performed via a laparoscopic or robotic approach internally. The RUC also compared CPT code 49623 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU = 4.13, 40 minutes of intra-service and total time) and noted that a recommended work RVU of 5.00 is appropriately higher than that of 34812 given the higher intra-service time and relative work.

As additional support, the RUC considered CPT code 57267, *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88, 45 minutes of intra-service and total time) and CPT code 63295, *Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)* (work RVU = 5.25, 45 minutes of intra-service time and 55 minutes total time) which bracket the work included in CPT code 49623. **The RUC recommends a work RVU of 5.00 for CPT code 49623.**

Implantation of Absorbable Mesh or Other Prothesis for Delayed Closure

15778 ***Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma***
The RUC reviewed the survey results from 36 surgeons for CPT code 15778 and determined that the survey 25th percentile work RVU of 8.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 213 minutes of total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data.

The RUC agreed with the specialties that the typical patient requiring this procedure will have a large abdominal wall defect as a result of necrotizing infection and extensive debridement of all involved skin, subcutaneous tissue, fascia and muscle. For some patients, the external genitalia and perineum may also be involved. These patients will all have inpatient status and will require a visit later on the same date at the level of 99232 to monitor the sutured wound edges of skin/mesh for swelling and pulling and to monitor for pain control. Intake/output and vital signs are evaluated, including fluid and electrolyte status and renal function. Orders for prophylaxis for DVT and beta-blockers are reviewed and adjusted as needed. The surgeon will communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise treatment plan(s) (moderate complexity MDM); and complete medical record documentation.

The RUC reviewed the top survey key reference services and agreed they were poor comparators because the intra-times and total times were much lower. To support a work RVU of 8.00, the RUC compared CPT code 15778 to MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and agreed that 15778 was appropriately bracketed by these two codes using magnitude estimation. **The RUC recommends a work RVU of 8.00 for CPT code 15778**.

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RUC Referral to CPT
The RUC recommends CPT code 49623 be referred to CPT to editorially revise the guidelines to specify "total or near total non-infected" mesh removal and revise the descriptor for CPT code 49623 to specify "total or near total non-infected" mesh removal. *The CPT Editorial Panel incorporated these changes at their May 2021 meeting.*

Work Neutrality
The RUC's recommendation for this code family will result in an overall work savings that should be redistributed back to the Medicare conversion factor. The specialty society survey was conducted for all the base codes as 000-day global. This contrasts with the former code structure for this family where all the hernia repair codes had a 090-day global period, and as a result, post-operative visits after the date of the procedure will now be separately reported, when performed. When evaluating work neutrality, AMA staff performed several analyses, including an analysis assuming all bundled visits other than discharge services would continue to be separately reported, to determine whether the RUC recommendation was work neutral. Under all scenarios, including assumptions that all E/M visits will be separately reported using the current CMS values, the RUC recommendation for this code family would be work neutral.

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the special society submitted standard 090-day global period clinical staff inputs as the conversion of this code family from 090-day to 000-day global period does not impact the fact that these are major surgical procedures. The PE Subcommittee removed medical supply item SA054 *Post-Operative Incision Care Suture Pack* from the submitted practice expense inputs because SA054 must be allocable to the service period; this would not be possible as this code family consists of 000-day global codes and one ZZZ code. The PE Subcommittee recommended that the specialties address post-operative work and practice expense needs such as suture removal through the CPT process. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Integumentary System** **Skin, Subcutaneous, and Accessory Structures** **Debridement**				
11004		*Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum*		
11005		*abdominal wall, with or without fascial closure*		
11006		*external genitalia, perineum and abdominal wall, with or without fascial closure*		
		(If orchiectomy is performed, use 54520)		

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(If testicular transplantation is performed, use 54680)

+11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)*

(Use 11008 in conjunction with 10180, 11004-11006)

(Report skin grafts or flaps separately when performed for closure at the same session as

11004-11008)

~~(When insertion of mesh is used for closure, use 49568)~~

(For implantation of absorbable mesh or other prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect[s] due to soft tissue infection or trauma, use 15778)

Repair (Closure)
Other Flaps and Grafts

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

(For implantation of biologic implants for soft tissue reinforcement in tissues other than breast and trunk, use 17999)

(For bilateral breast procedure, report 15777 twice. Do not report modifier 50 in conjunction with 15777)

~~(For implantation of mesh or other prosthesis for open incisional or ventral hernia repair, use 49568 in conjunction with 49560-49566)~~

~~(For insertion of mesh or other prosthesis for closure of a necrotizing soft tissue infection wound, use 49568 in conjunction with 11004-11006)~~

(For topical application of skin substitute graft to a wound surface, see 15271-15278)

~~(For repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]), use 46707)~~

~~(For insertion of mesh or other prosthesis for repair of pelvic floor defect, use 57267)~~

~~(For implantation of non-biologic or synthetic implant for fascial reinforcement of the abdominal wall, use 0437T)~~

(The supply of biologic implant should be reported separately in conjunction with 15777)

●15778	C1	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	000	8.00

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		(For repair of anorectal fistula with plug [eg, porcine small intestine submucosa {SIS}], use 46707) (For implantation of mesh or other prosthesis for anterior abdominal hernia repair or parastomal hernia repair, see 49591-49622) (For insertion of mesh or other prosthesis for repair of pelvic floor defect, use 57267) (For implantation of non-biologic or synthetic implant for fascial reinforcement of the abdominal wall, use 0437T)		

Other Procedures

+15847 *Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)*

(Use 15847 in conjunction with 15830)

(For ~~abdominal wall~~ inguinal hernia repair, see 49491-4952~~549587~~)

(For anterior abdominal hernia[s] repair, see 49591-49618)

(To report other abdominoplasty, use 17999)

Digestive System
Abdomen, Peritoneum, and Omentum
Repair
Hernioplasty, Herniorrhaphy, Herniotomy

The hernia repair codes in this section are categorized primarily by the type of hernia (inguinal, femoral, lumbar, omphalocele, anterior abdominal, parastomal~~incisional, etc~~).

Some types of hernias are further categorized as "initial" or "recurrent" based on whether or not the hernia has required previous repair(s).

Additional variables accounted for by some of the codes include patient age and clinical presentation (reducible vs. incarcerated or strangulated).

~~With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prostheses is not separately reported.~~

The excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair (eg, 44120, 54520, and 58940) in addition to the appropriate code for the repair of the strangulated hernia.

(For reduction and repair of intra-abdominal hernia, use 44050)

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	(For debridement of abdominal wall, see 11042, 11043)
	~~(Codes 49491-49651 are unilateral procedures. For bilateral procedure, report 49491-49566, 49570-49651 with modifier 50. Report add-on code 49568 twice, when performed bilaterally. Do not report modifier 50 in conjunction with 49568)~~
	(49491-49557, 49600, 49605, 49606, 49610, 49611, 49650, 49651 are unilateral procedures. For bilateral procedure, use modifier 50)
	(Do not report modifier 50 in conjunction with 49591-49622)
49491	*Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible*
49492	*incarcerated or strangulated*
	(Do not report modifier 63 in conjunction with 49491, 49492)
	(Postconception age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are older than 50 weeks postconception age and younger than age 6 months at the time of surgery, should be reported using codes 49495, 49496)
49495	*Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible*
49496	*incarcerated or strangulated*
	(Do not report modifier 63 in conjunction with 49495, 49496)
	(Postconception age equals gestational age at birth plus age in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are younger than or up to 50 weeks postconception age but younger than 6 months of age since birth, should be reported using codes 49491, 49492. Inguinal hernia repairs on infants age 6 months to younger than 5 years should be reported using codes 49500-49501)
49500	*Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible*
49501	*incarcerated or strangulated*
49505	*Repair initial inguinal hernia, age 5 years or older; reducible*
49507	*incarcerated or strangulated*
	(For inguinal hernia repair, with simple orchiectomy, see 49505 or 49507 and 54520)
	(For inguinal hernia repair, with excision of hydrocele or spermatocele, see 49505 or 49507 and 54840 or 55040)
49520	*Repair recurrent inguinal hernia, any age; reducible*

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49521		*incarcerated or strangulated*		
49525		*Repair inguinal hernia, sliding, any age*		
		(For incarcerated or strangulated inguinal hernia repair, see 49496, 49501, 49507, 49521)		
49540		*Repair lumbar hernia*		
49550		*Repair initial femoral hernia, any age; reducible*		
49553		*incarcerated or strangulated*		
49555		*Repair recurrent femoral hernia; reducible*		
49557		*incarcerated or strangulated*		
~~(D)49560~~	-	~~Repair initial incisional or ventral hernia; reducible~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 11.92)~~
~~(D)49561~~	-	~~incarcerated or strangulated~~ (49560, 49561 have been deleted. For repair of initial incisional or ventral hernia, see 49591-49596)	~~090~~	~~N/A~~ ~~(2021 work RVU = 15.38)~~
~~(D)49565~~	-	~~Repair recurrent incisional or ventral hernia; reducible~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 12.37)~~
~~(D)49566~~	-	~~incarcerated or strangulated~~ (49565, 49566 have been deleted. For repair of recurrent incisional or ventral hernia, see 49613-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 15.53)~~

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~~————————Coding Tip————————~~ **~~Restrictions for Reporting Insertion of Mesh and Other Prostheses with Hernia Repairs~~** ~~With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prostheses is not separately reported.~~ ~~*CPT Coding Guidelines, Hernioplasty, Herniorrhaphy, Herniotomy*~~				
~~(D)49568~~	-	~~Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)~~ ~~(Use 49568 in conjunction with 11004-11006, 49560-49566)~~ (49568 has been deleted. For implantation of mesh or other prosthesis for anterior abdominal hernia repair, see 49591-49618)	~~ZZZ~~	~~N/A~~ ~~(2021 work RVU = 4.88)~~
~~(D)49570~~	-	~~Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 6.05)~~
~~(D)49572~~	-	~~incarcerated or strangulated~~ (49570, 49572 have been deleted. For epigastric hernia repair see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 7.87)~~
~~(D)49580~~	-	~~Repair umbilical hernia, younger than age 5 years; reducible~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 4.47)~~
~~(D)49582~~	-	~~incarcerated or strangulated~~ (49580, 49582 have been deleted. For umbilical hernia repair younger than age 5 years, see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 7.13)~~
~~(D)49585~~	-	~~Repair umbilical hernia, age 5 years or older; reducible~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 6.59)~~

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~~(D)49587~~	-	~~incarcerated or strangulated~~ (49585, 49587 have been deleted. For umbilical hernia repair age 5 years and older, see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 7.08)~~
~~(D)49590~~	-	~~Repair spigelian hernia~~ (49590 has been deleted. For spigelian hernia repair, see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 8.90)~~

Codes 49591-49618 describe repair of an anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian) by any approach (ie, open, laparoscopic, robotic). Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired. For example, "Swiss cheese" defects (ie, multiple separate defects) would be measured from the superior most aspect of the upper defect to the inferior most aspect of the lowest defect. In addition, the hernia defect size should be measured prior to opening the hernia defect(s) (ie, during repair the fascia will typically retract creating a falsely elevated measurement).

When both reducible and incarcerated/strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated/strangulated. For example, one 2 cm reducible initial incisional hernia and one 4 cm incarcerated initial incisional hernia~~s~~ separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudad distance of 8 cm (49594).

Inguinal, femoral, lumbar, omphalocele and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 59 as appropriate.

Codes 49621, 49622 describe repair of a parastomal hernia (initial or recurrent) by any approach (ie, open, laparoscopic, robotic). Code 49621 is reported for repair of a reducible parastomal hernia and code 49622 is reported for an incarcerated or strangulated parastomal hernia.

Implantation of mesh or other prosthesis, when performed, is included in 49591-49622 and may not be separately reported. For total or near-total removal of non-infected mesh when performed, use 49623 in conjunction with 49591-49622. For removal of infected mesh, see 11004, 11005, 11006, 11008.

Measuring Total Length of Anterior Abdominal Hernia Defect(s)

Hernia measurements are performed either in the transverse or craniocaudal dimension. The total length of the defect(s) corresponds to the maximum width or height of an oval drawn to encircle the outer perimeter of all repaired defects. If the defects are not contiguous and are separated by greater than or equal to 10 cm of intact fascia, total defect size is the sum of each defect measured individually.

Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.

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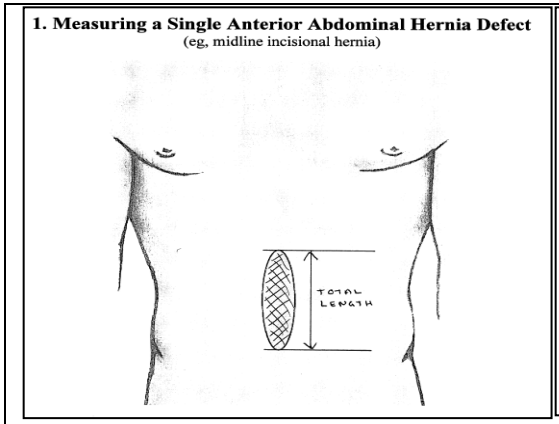

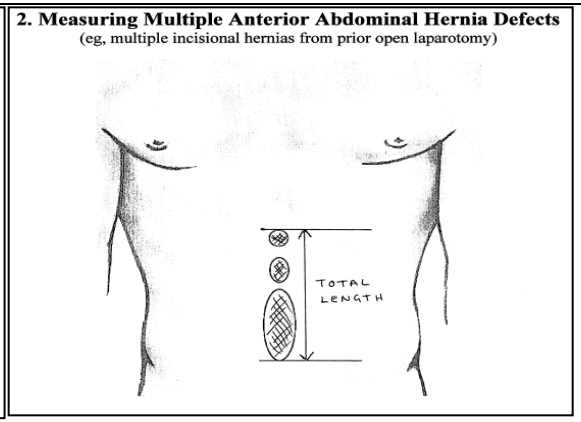

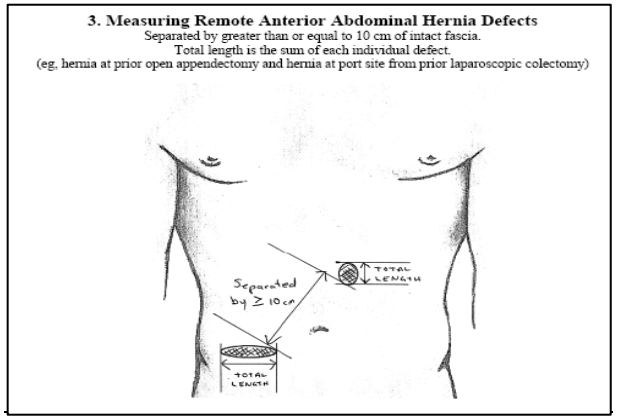

●49591	C2	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible	000	6.27
●49592	C3	less than 3 cm, incarcerated or strangulated	000	9.00
●49593	C4	3 cm to 10 cm, reducible	000	10.80
●49594	C5	3 cm to 10 cm, incarcerated or strangulated	000	14.00

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●49595	C6	greater than 10 cm, reducible	000	14.88
●49596	C7	greater than 10 cm, incarcerated or strangulated	000	20.00
●49613	C8	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible	000	7.75
●49614	C9	less than 3 cm, incarcerated or strangulated	000	10.79
●49615	C10	3 cm to 10 cm, reducible	000	12.00
●49616	C11	3 cm to 10 cm, incarcerated or strangulated	000	16.50
●49617	C12	greater than 10 cm, reducible	000	16.97
●49618	C13	greater than 10 cm, incarcerated or strangulated	000	24.00
●49621	C14	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible	000	14.24
●49622	C15	incarcerated or strangulated	000	18.00
+●49623	C16	Removal of total or near-total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure) (Use 49623 in conjunction with 49591-49622) (For removal of infected mesh, use 11008)	ZZZ	5.00

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Laparoscopy *Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.* *49650 Laparoscopy, surgical; repair initial inguinal hernia* *49651 repair recurrent inguinal hernia*				
~~(D)49652~~	-	~~Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible~~ ~~(Do not report 49652 in conjunction with 44180, 49568)~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 11.92)~~
~~(D)49653~~	-	~~incarcerated or strangulated~~ ~~(Do not report 49653 in conjunction with 44180, 49568)~~ (49652, 49653 have been deleted. To report laparoscopic repair of ventral, umbilical, spigelian or epigastric hernia, see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 14.94)~~
~~(D)49654~~	-	~~Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible~~ ~~(Do not report 49654 in conjunction with 44180, 49568)~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 13.76)~~
~~(D)49655~~	-	~~incarcerated or strangulated~~ ~~(Do not report 49655 in conjunction with 44180, 49568)~~ (49654, 49655 have been deleted. To report laparoscopic repair of incisional hernia, see 49591-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 16.84)~~
~~(D)49656~~	-	~~Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible~~ ~~(Do not report 49656 in conjunction with 44180, 49568)~~	~~090~~	~~N/A~~ ~~(2021 work RVU = 15.08)~~

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~~(D)49657~~	-	~~incarcerated or strangulated~~ ~~(Do not report 49657 in conjunction with 44180, 49568)~~ (49656, 49657 have been deleted. To report laparoscopic repair of recurrent incisional hernia, see 49613-49618)	~~090~~	~~N/A~~ ~~(2021 work RVU = 22.11)~~

Category III Codes

~~+~~*0437T* *Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)*

~~(For implantation of mesh or other prosthesis for open incisional or ventral hernia repair, use 49568 in conjunction with 49560, 49561, 49565, 49566)~~

~~(For insertion of mesh or other prosthesis for closure of a necrotizing soft tissue infection wound, use 49568 in conjunction with 11004, 11005, 11006)~~

(For implantation of mesh or other prosthesis for anterior abdominal hernia[s] repair or parastomal hernia repair, see 49591-49622)

(For implantation of absorbable mesh or other prosthesis for delayed closure of defect[s] [ie, external genitalia, perineum, abdominal wall] due to soft tissue infection or trauma, use 15778)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49591 Tracking Number C2 Original Specialty Recommended RVU: **6.27**
Presented Recommended RVU: **6.27**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **6.27**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a painful mass through the umbilicus that disappears in supine position. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 72% , In the ASC 28%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 82% , Overnight stay-less than 24 hours 18% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including mesh. Assistance is provided in transfer of the patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: An infraumbilical incision is made. Dissection of the subcutaneous tissues surrounding the hernia sac is performed. The overlying umbilical dermis is detached from the hernia sac. The fascia is circumferentially dissected surrounding the periphery of the hernia sac. The hernia sac is opened and adhesions to the hernia sac are divided. The hernia sac is excised. The hernia defect is measured at less than 3 cm in diameter. A mesh is selected to provide adequate overlap of the hernia defect. The mesh is inserted preperitoneal or intraperitoneal and sutured to the abdominal wall. The hernia defect is closed with interrupted sutures over the top the mesh. Redundant umbilical skin is excised. The umbilical dermis is sutured to the abdominal fascia. Layered closure is performed.

Description of Post-Service Work: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discontinue prophylactic antibiotic therapy, as appropriate. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. When safe to discharge patient to home, conduct final exam.

Auscultate heart, lungs, and abdomen for bowel sounds. Assess for problems such as ileus, intestinal ischemia, and urinary retention. Assess pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing) with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49591					
Sample Size:	1950	**Resp N:**	39			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	3.00	10.00	**20.00**	40.00	76.00	
Survey RVW:	4.95	6.27	**8.00**	10.00	16.00	
Pre-Service Evaluation Time:			**25.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	20.00	40.00	**45.00**	60.00	90.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	49591	**Recommended Physician Work RVU: 6.27**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31600	000	5.56	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43210	000	7.75	**RUC Time**

CPT Descriptor Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36475	000	5.30	**RUC Time**	109,583

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52352	000	6.75	**RUC Time**	24,811

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 15.3 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 15.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 49591	Top Key Reference CPT Code: 31600	2nd Key Reference CPT Code: **43210**
Median Pre-Service Time	43.00	60.00	58.00
Median Intra-Service Time	45.00	30.00	60.00
Median Immediate Post-service Time	20.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**108.00**	**120.00**	**148.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	67%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	50%	17%
Physical effort required	17%	83%	0%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	50%	17%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	50%	33%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	50%	33%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	67%	33%
Physical effort required	0%	33%	67%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	67%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49591

We recommend a work RVU of 6.27, which is the survey 25th percentile. The typical patient will be discharged on the same day of the procedure.

Pre-service time

Package time has been reduced so as to not exceed survey median data.

Post-service time

Package time has been reduced so as to not exceed survey median data.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49591 is somewhat less or similar than reference code 31600. Ref2: The respondents indicated the intensity/complexity of survey code 49591 is similar to somewhat more than reference code 43210.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	**5.30**	0.097	0.056	94	34	45	15
49591	**Initial, Reduc, < 3cm**	**6.27**	**0.113**	**0.058**	**108**	**43**	**45**	**20**
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	**6.75**	0.118	0.057	118	53	45	20

Other Code Comparison

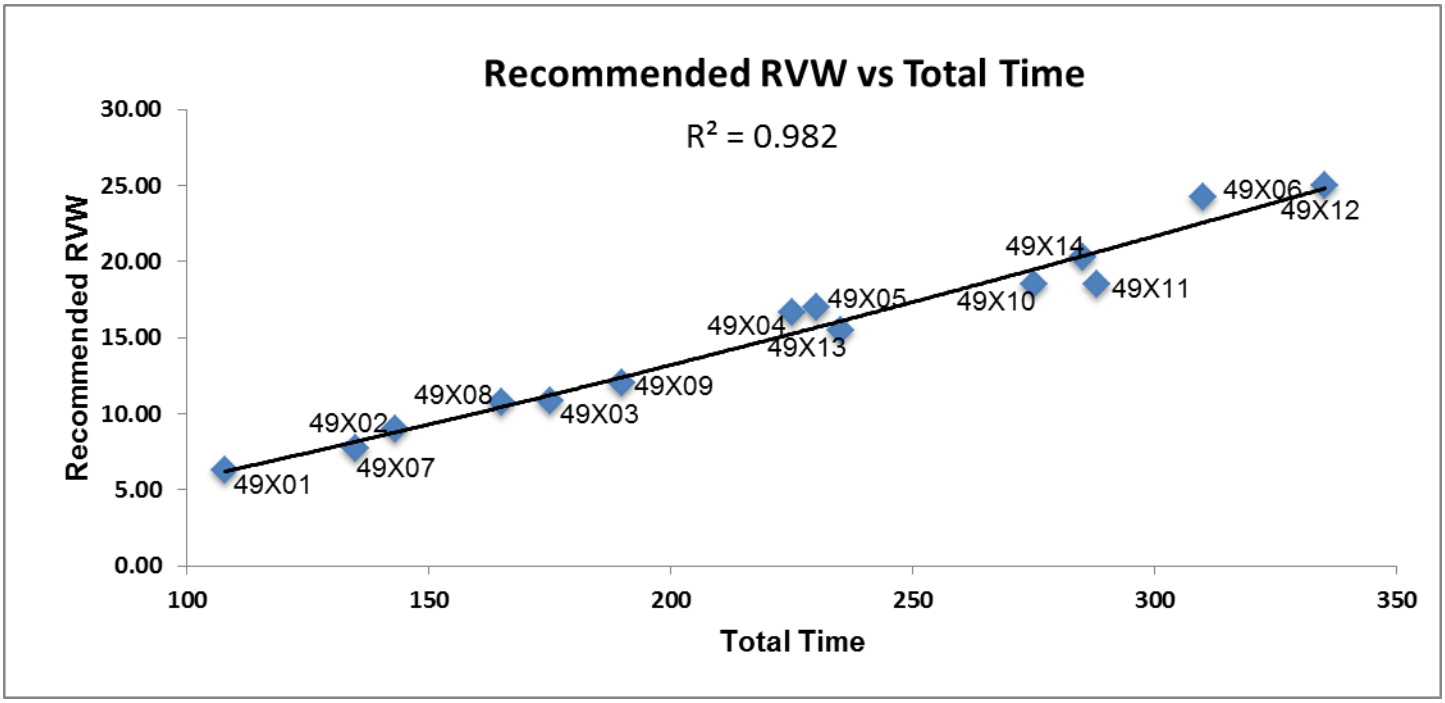
Codes 45390 and 31276, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
45390	Colonoscopy, flexible; with endoscopic mucosal resection	**6.04**	0.117	0.073	83	23	45	15
49591	**Initial, Reduc, < 3cm**	**6.27**	**0.113**	**0.058**	**108**	**43**	**45**	**20**
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	**6.75**	0.127	0.069	98	33	45	20

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

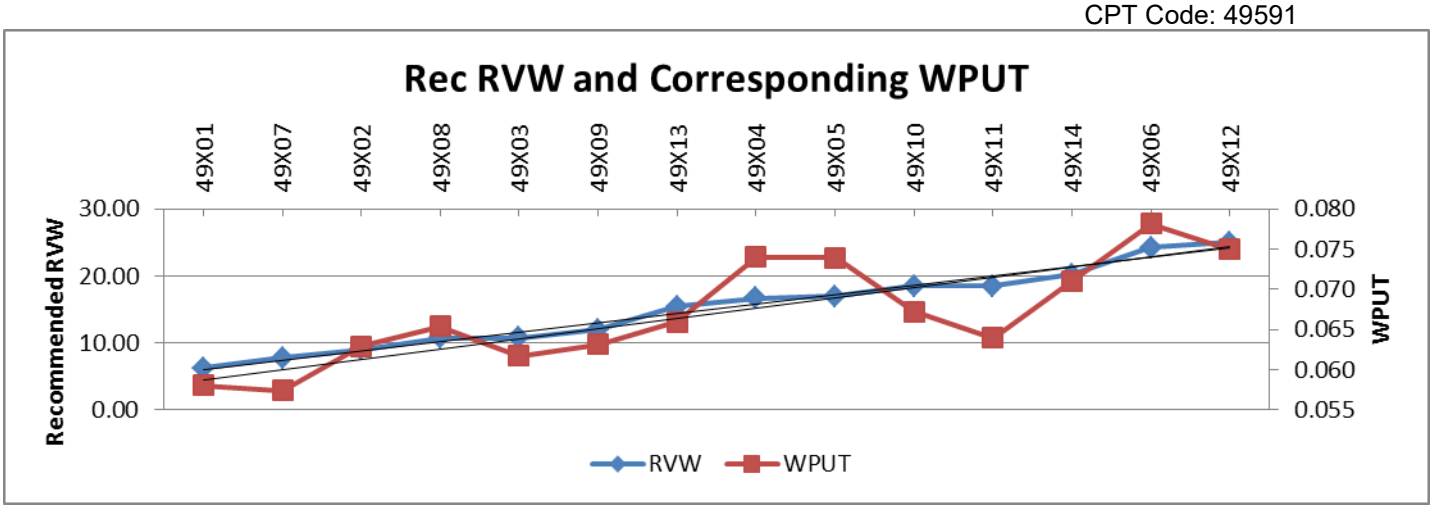


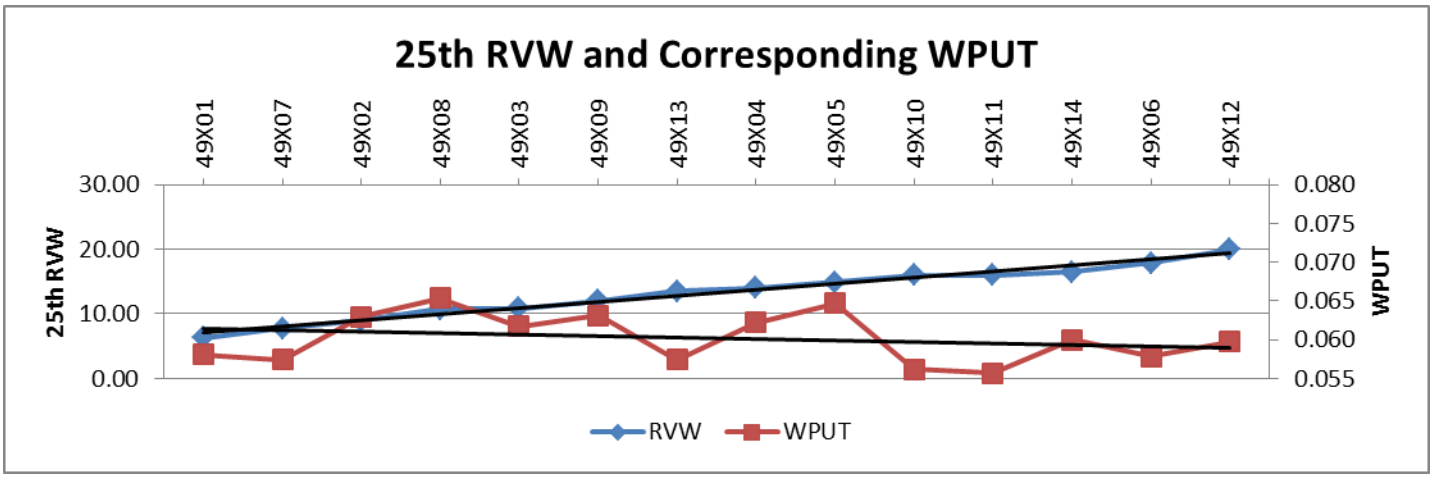
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?
As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an

ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49560 Repair initial incisional or ventral hernia; reducible 090
49570 Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure) 090
49585 Repair umbilical hernia, age 5 years or older; reducible 090
49590 Repair spigelian hernia 090
49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible 090
49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Commonly

Specialty colorectal surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
43,628 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 39265 Percentage 89 %

Specialty Colorectal Surgery Frequency 2181 Percentage 4.99 %

Specialty Other Surgery Frequency 2181 Percentage 4 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns

warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49592 Tracking Number C3 Original Specialty Recommended RVU: **9.00**
Presented Recommended RVU: **9.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **9.00**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a history of painful swelling in the umbilical region. Physical exam reveals an umbilical hernia that is tender and nonreducible by manual manipulation. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 92% , In the ASC 8%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 39% , Overnight stay-less than 24 hours 39% , Overnight stay-more than 24 hours 22%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 91%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable mass of the hernia contents incarcerated in the subcutaneous tissue is easily identified , and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including mesh. Assistance is provided in transfer of the patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: An infraumbilical skin incision is made. Dissection of the subcutaneous tissues surrounding the hernia sac is performed. The overlying umbilical dermis is detached from the hernia sac. This is exacerbated by the location of the incarcerated hernia contents occupying the central space of the operative field making the dissection more challenging. Separation is performed without damaging the intra-abdominal contents incarcerated in the hernia sac. The hernia sac is opened and the contents are inspected. Adhesiolysis is performed to free omentum and intestines incarcerated within the hernia sac. The reduced hernia contents are inspected for viability. The hernia sac is excised. The hernia defect is measured and found to span less than 3 cm. A mesh with adequate overlap of the abdominal wall is sutured to the abdominal wall circumferentially. The hernia defect is closed over the mesh. Redundant skin is excised as appropriate. The umbilical dermis is sutured to the abdominal fascia.

Description of Post-Service Work:

Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49592					
Sample Size:	1950	**Resp N:**	39			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**10.00**	20.00	100.00	
Survey RVW:	5.60	9.00	**12.00**	15.48	20.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	30.00	50.00	**60.00**	75.00	140.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49592	**Recommended Physician Work RVU: 9.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33956	000	16.00	**RUC Time**

CPT Descriptor Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36905	000	9.00	**RUC Time**	41,205

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 2 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 15.3 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 15.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 49592	Top Key Reference CPT Code: 11005	2nd Key Reference CPT Code: 33956
Median Pre-Service Time	53.00	60.00	60.00
Median Intra-Service Time	60.00	120.00	90.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	70.00
Median Other Hospital Visit Time	0.0	55.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**143.00**	**265.00**	**250.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	17%	17%	50%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	17%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	0%	17%	83%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	17%	0%	50%	17%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	33%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	67%	17%
Physical effort required	17%	50%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	33%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49592

We recommend a work RVU of 9.00, which is the survey 25th percentile.

Pre-service time

Package time has been reduced so as to not exceed survey median data.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99231. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (straightforward or low-complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 10 minutes for 99231 has been added to the survey immediate postoperative time (total = 30 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49592 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49592 is similar to reference code 33956.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	**9.00**	0.106	0.071	126	31	75	20	
49592	**Initial, I/S, < 3cm**	**9.00**	**0.123**	**0.063**	**143**	**53**	**60**	**30**	~~**99231**~~
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography,	**10.42**	0.104	0.074	141	31	90	20	

	fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit								

Other Code Comparison

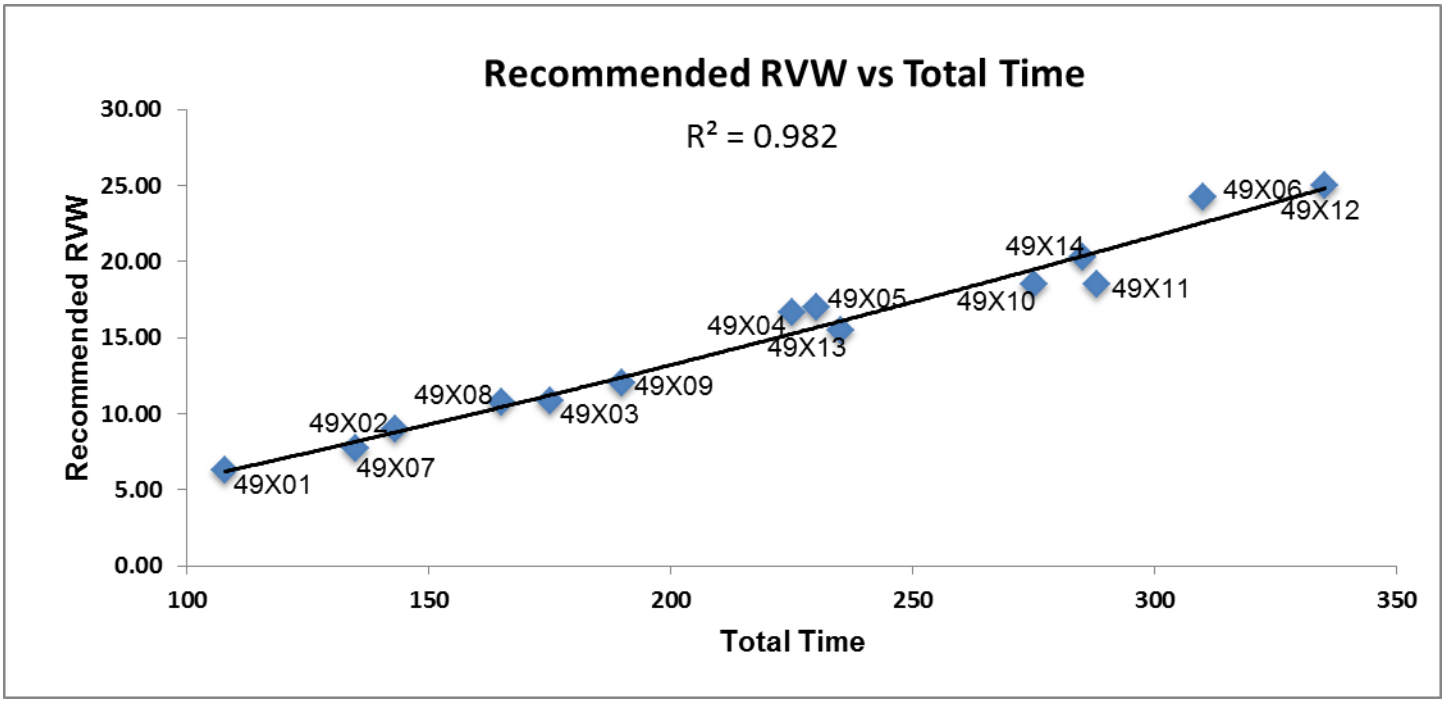
Codes 33991 and 92920, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	**8.84**	0.129	0.078	113	25	60	28	
49592	**Initial, I/S, < 3cm**	**9.00**	**0.123**	**0.063**	**143**	**53**	**60**	**30**	~~**99231**~~
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**9.85**	0.126	0.078	127	29	68	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



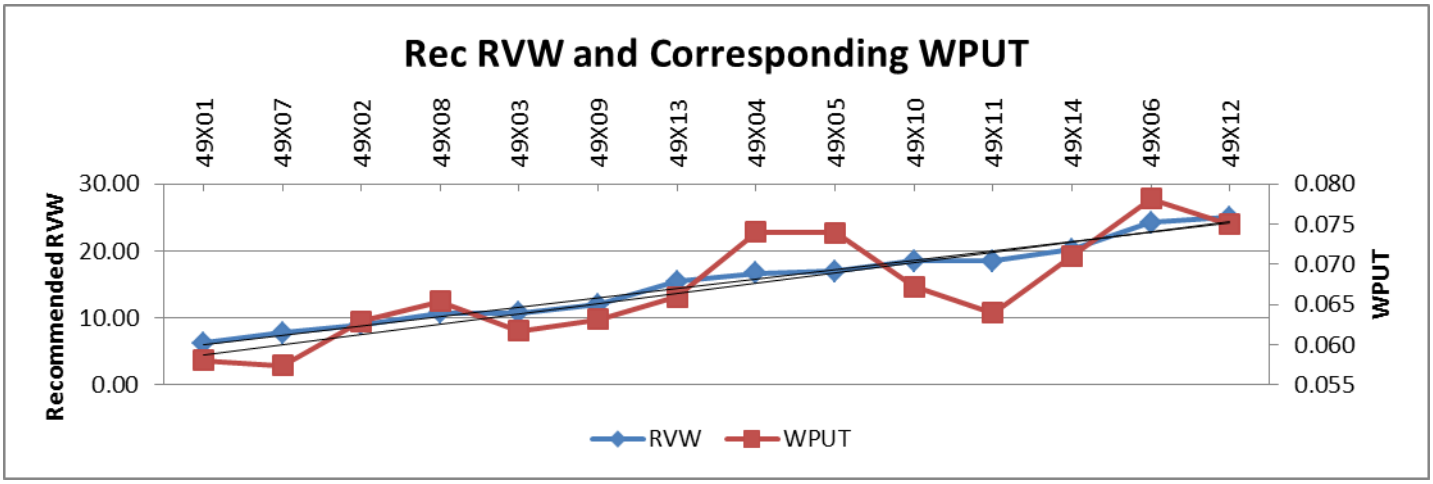
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

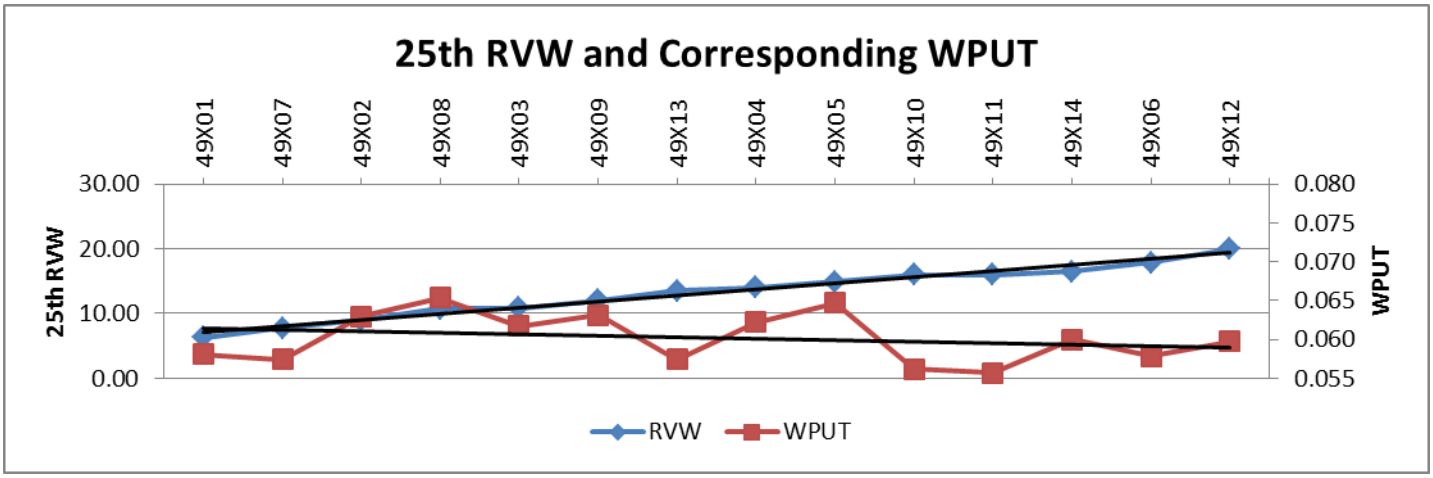
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**

49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial,** **I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent,** **I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial,** **I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent,** **I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the

IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49561 Repair initial incisional or ventral hernia; incarcerated or strangulated 090
49572 Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated 090
49587 Repair umbilical hernia, age 5 years or older; incarcerated or strangulated 090
49590 Repair spigelian hernia 090
49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Commonly

Specialty colorectal surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
23,602 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 21242 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 1180 Percentage 4.99 %

Specialty Other Surgery Frequency 1180 Percentage 4.99 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49593 Tracking Number C4 Original Specialty Recommended RVU: **10.80**
Presented Recommended RVU: **10.80**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **10.80**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male with a prior laparotomy has developed a bulge in the midline incision. The defect has been increasing in size during follow-up. He has symptoms of pain and local tenderness. He has had no history of incarceration or bowel obstruction. Physical exam reveals a reducible incisional hernia. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 5%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 31% , Overnight stay-less than 24 hours 59% , Overnight stay-more than 24 hours 10%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 85%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies approximately half of the anterior abdominal wall correlating with the extent of the prior laparotomy. Adhesions to the abdominal wall are divided sharply to free the anterior abdominal wall adequately for subsequent mesh landing. The hernia defect is visualized. Great care is taken to avoid injury to the intestine or other intra-abdominal contents. Each separate defect within the overall hernia defect contains a separate component of adipose and intestine that requires safe reduction. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia. All of the defects are measured and summed with a minimum length of 3 cm and maximum length of 10 cm. Peritoneal flaps are created for placement of

mesh. When appropriate, the fascial defect is approximated with sutures. A mesh is selected to provide adequate overlap of the hernia defect. the mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing multiple sutures and tacks.. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Fascial incisions from laparoscopic ports larger than 1 cm in diameter are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49593					
Sample Size:	1950	**Resp N:**	41			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	8.00	**20.00**	30.00	100.00	
Survey RVW:	8.00	10.80	**13.00**	15.00	18.32	
Pre-Service Evaluation Time:			**30.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	40.00	60.00	**90.00**	120.00	240.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	49593	**Recommended Physician Work RVU: 10.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11006	000	13.10	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11004	000	10.80	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 2 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 19.5 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 49593	Top Key Reference CPT Code: 11006	2nd Key Reference CPT Code: **11004**
Median Pre-Service Time	55.00	65.00	65.00
Median Intra-Service Time	90.00	120.00	90.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	55.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**175.00**	**270.00**	**240.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	13%	0%	75%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	25%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	0%	88%
Physical effort required	13%	25%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	13%	63%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	20%	60%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	40%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	0%	80%
Physical effort required	20%	60%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	60%	20%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia

defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal

only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49593

We recommend a work RVU of 10.80, which is the survey 25th percentile.

Pre-service time

Evaluation package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99231. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (straightforward or low-complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 10 minutes for 99231 has been added to the survey immediate postoperative time (total = 30 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49593 is somewhat more than reference code 11006. Ref 2: The respondents indicated the intensity/complexity of survey code 49593 is similar to somewhat more than reference code 11004.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment,	**10.42**	0.104	0.074	141	31	90	20	

	including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit								
49593	**Initial, Reduc, 3-10cm**	**10.80**	**0.101**	**0.062**	**175**	**55**	**90**	**30**	**~~99231~~**
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	

Other Code Comparison

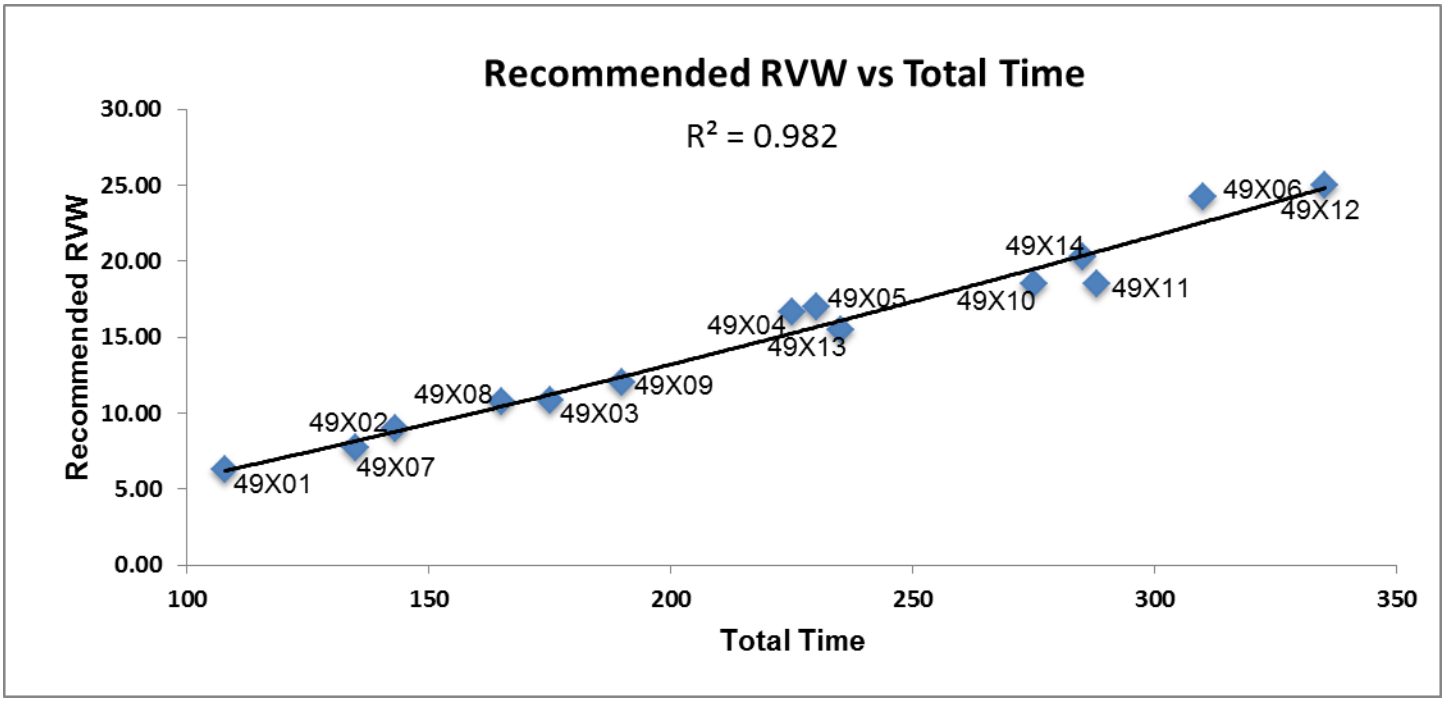
Codes 92920 and 92924, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**9.85**	0.126	0.078	127	29	68	30	
49593	**Initial, Reduc, 3-10cm**	**10.80**	**0.101**	**0.062**	**175**	**55**	**90**	**30**	**~~99231~~**
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**11.74**	0.125	0.082	143	29	84	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



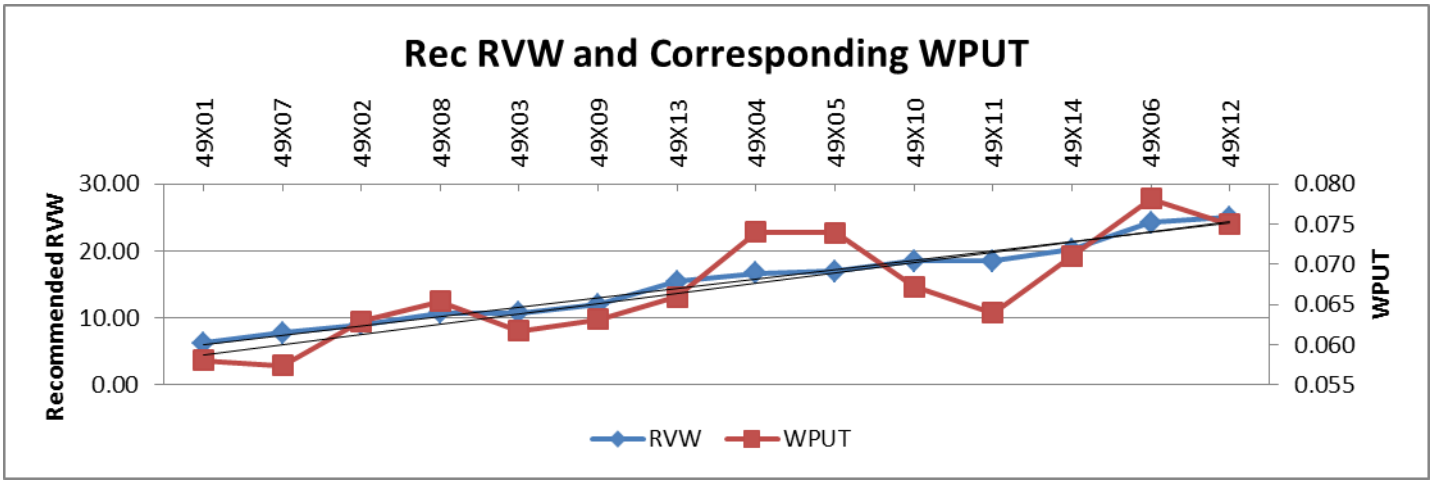
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

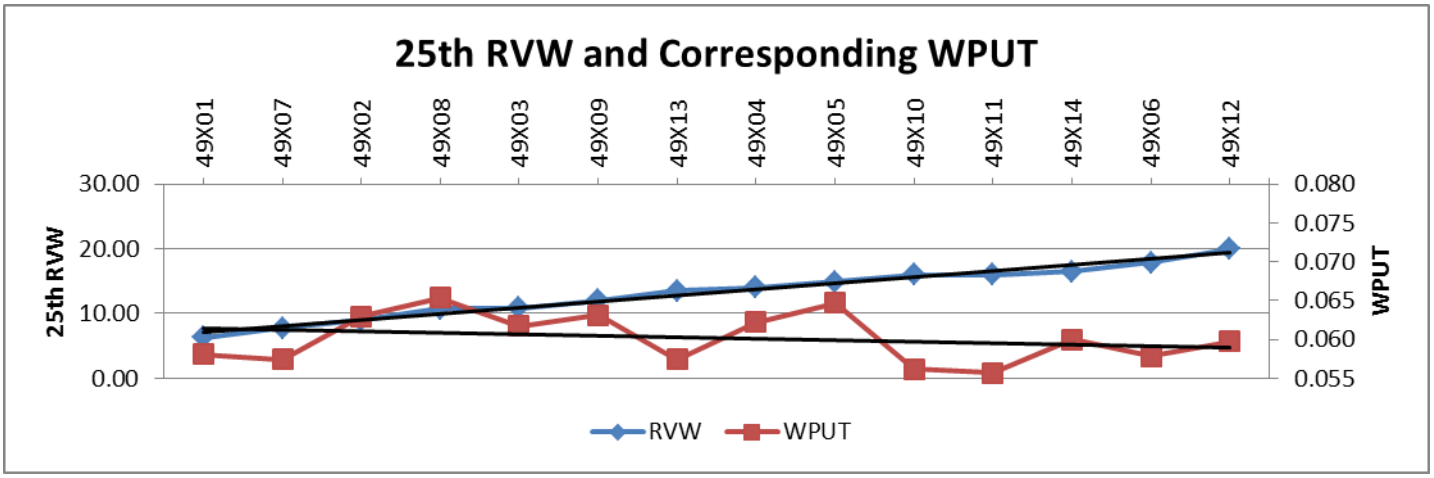
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
4961	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**

49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the

IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
48614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49560 Repair initial incisional or ventral hernia; reducible 090
49570 Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure) 090
49585 Repair umbilical hernia, age 5 years or older; reducible 090
49590 Repair spigelian hernia 090
49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible 090
49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Commonly

Specialty colorectal surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
12,662 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty General Surgery Frequency 11396 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 633 Percentage 4.99 %

Specialty Other Surgery Frequency 633 Percentage 4.99 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate

the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49594 Tracking Number C5 Original Specialty Recommended RVU: **16.65**
Presented Recommended RVU: **16.65**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **14.00**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male with a prior laparotomy has developed an incisional hernia in the midline incision. Over the past few months, the defect has become chronically protuberant. He reports increasing pain and discomfort. Physical exam reveals a hernia that is tender and nonreducible by manual manipulation. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 12% , Overnight stay-less than 24 hours 32% , Overnight stay-more than 24 hours 56%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The masses of the incarcerated hernia contents are palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies approximately half of the abdominal wall correlating with the extent of the prior laparotomy. Adhesions to the abdominal wall are divided sharply to free the anterior abdominal wall adequately for subsequent mesh landing. The incarcerated/strangulated bowel, mesentery and omentum are carefully reduced with dissection of the adhesions and sac to clear the defects for repair. Care is taken to avoid injury to the incarcerated intestine and omentum. Each separate defect within the overall hernia defect contains a separate component of adipose and intestine that requires safe reduction. This requires manipulation both intra-abdominally with minimally

invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced tissue is examined for viability and any inadvertent injury. The hernia sac is reduced and resected as needed to expose the fascial edges of the defect(s). The hernia defect is visualized. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia. All of the defects are measured and summed with a minimum of 3 cm and maximum of 10 cm. Peritoneal flaps are created for placement of mesh. When appropriate, the fascial defect is approximated with sutures. A mesh is selected to provide adequate overlap of the hernia defect. The mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing multiple sutures and tacks. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Fascial incisions from laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49594					
Sample Size:	1950	**Resp N:**	41			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	3.00	**8.00**	20.00	100.00	
Survey RVW:	10.90	14.00	**16.65**	20.00	24.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	90.00	**120.00**	150.00	300.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49594	**Recommended Physician Work RVU: 14.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**40.00**	**33.00**	**7.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33891	000	20.00	**RUC Time**

CPT Descriptor Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 26.8 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 14.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 49594	Top Key Reference CPT Code: 11005	2nd Key Reference CPT Code: 33891
Median Pre-Service Time	65.00	60.00	110.00
Median Intra-Service Time	120.00	120.00	173.00
Median Immediate Post-service Time	40.00	30.00	40.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	55.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**225.00**	**265.00**	**323.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	18%	9%	45%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	18%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	27%	73%
Physical effort required	0%	27%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	27%	9%	64%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	50%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	33%	50%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	33%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49594

We recommend a work RVU of 16.65, which is the survey median.

Pre-service time

Evaluation and scrub, dress, wait package time has been reduced so as to not exceed survey median data. Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99232. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 20 minutes for 99232 has been added to the survey immediate postoperative time (total = 40 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49594 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49594 is similar to somewhat more than reference code 33889.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49594	**Initial, I/S, 3-10cm**	**16.65**	**0.121**	**0.074**	**225**	**65**	**120**	**40**	~~**99232**~~

Other Code Comparison

Codes 61645 and 93591, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

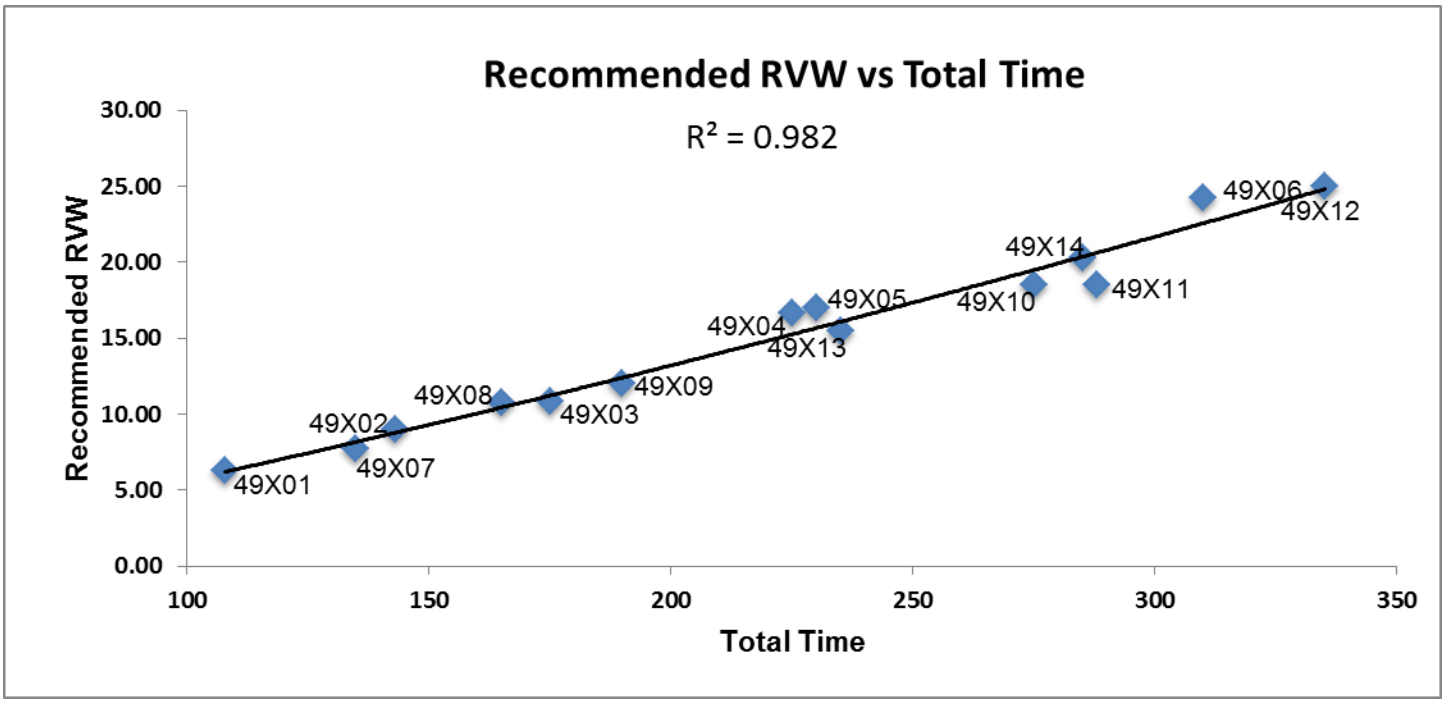
CPT Code: 49594

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	15.00	0.121	0.062	241	58	100	83	
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	225	65	120	40	~~99232~~
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	17.97	0.135	0.086	208	58	120	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



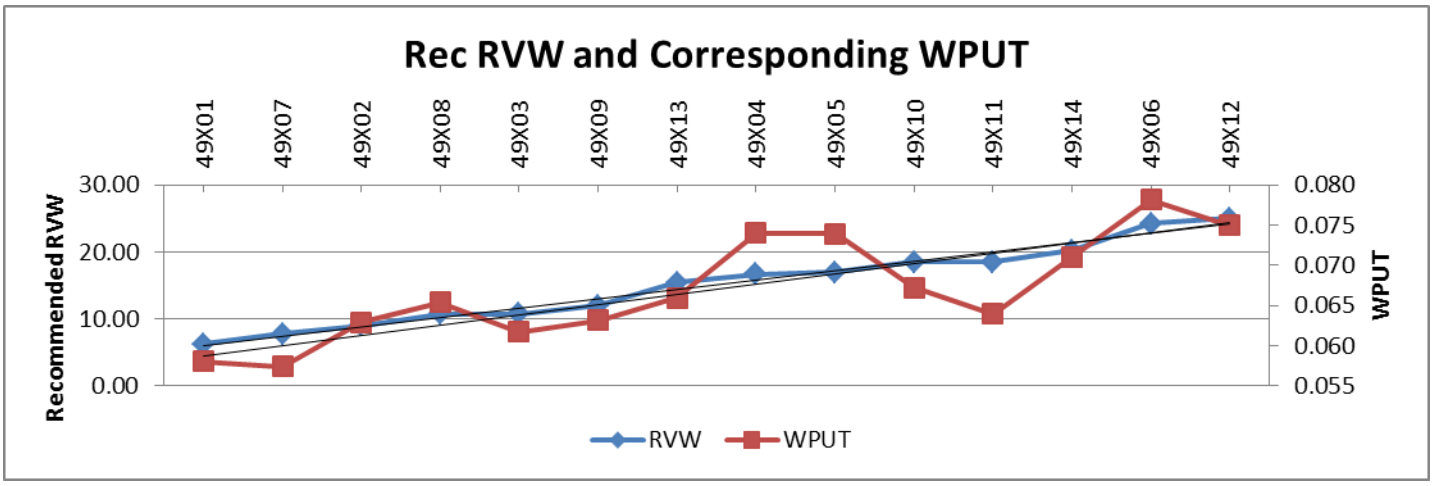
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

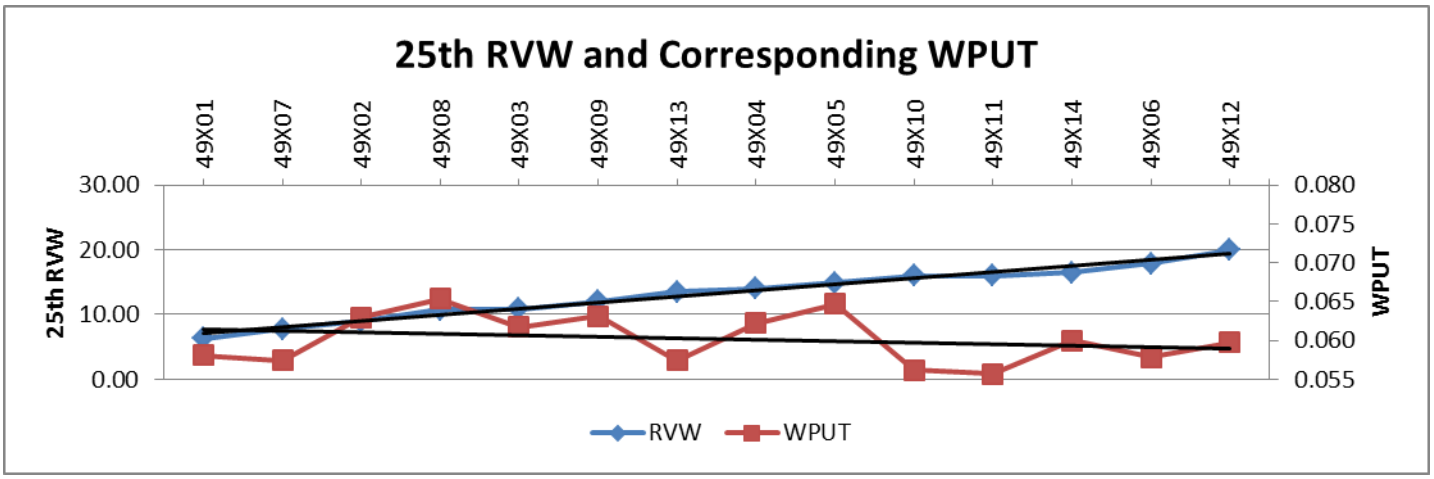
CPT	DESC		REC RVW	Total Time
49591	Initial, Reduc, < 3cm	25th	6.27	108
49613	Recurrent, Reduc, < 3cm	25th	7.75	135
49592	Initial, I/S, < 3cm	25th	9.00	143
49614	Recurrent, I/S, < 3cm	25th	10.79	165
49593	Initial, Reduc, 3-10cm	25th	10.80	175
49615	Recurrent, Reduc, 3-10cm	25th	12.00	190
49621	Parastomal, Reduc	median	15.50	235
49594	Initial, I/S, 3-10cm	median	16.65	225
49595	Initial, Reduc, > 10cm	median	17.00	230
49616	Recurrent, I/S, 3-10cm	median	18.50	275
49617	Recurrent, Reduc, > 10cm	median	18.53	288
49622	Parastomal, I/S	75th	20.25	285

49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3

minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49561 Repair initial incisional or ventral hernia; incarcerated or strangulated 090
49572 Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated090
49587 Repair umbilical hernia, age 5 years or older; incarcerated or strangulated 090
49590 Repair spigelian hernia 090
49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,231
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 6508 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 362 Percentage 5.00 %

Specialty Other Surgery Frequency 362 Percentage 5.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49595 Tracking Number C6 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **14.88**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old obese male with a prior laparotomy has developed incisional hernias with defects of varying sizes at multiple points. He has symptoms of pain and tenderness at the sites. Physical exam reveals multiple reducible incisional hernias. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Overnight stay-less than 24 hours 48% , Overnight stay-more than 24 hours 50%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 87%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. As the hernia extends across the majority of the anterior abdominal wall, location for insertion of the needle/trocar is selected based on the prior surgical history and the safest location to avoid intra-abdominal injury. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, and in additional areas as needed, all under direct vision. A field of adhesions occupies the entire anterior abdominal wall correlating with the extent of the prior laparotomy. The adhesions are divided sharply to free the anterior abdominal wall completely taking great care to avoid injury to the intestine. Each separate defect within the entire hernia defect contains adipose and intestinal components and requires a safe and effective clearance of tissue. The hernia defect is visualized. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia to include wide lateral clearance for adequate later mesh coverage. Peritoneal flaps are created for placement of mesh . The fascial defect is

approximated with sutures placed along the entire length of the defect. The appropriate size mesh is calculated after total defect length is documented. Adequate overlap of at least 5 cm in all directions is included in the calculation. A trocar is removed from the abdominal wall and the track is dilated to allow insertion of the large mesh into the peritoneal cavity. The mesh is oriented intra-abdominally. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing multiple sutures and numerous tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Fascial incisions from laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49595					
Sample Size:	1950	**Resp N:**	40			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	5.00	**10.00**	20.00	50.00	
Survey RVW:	10.00	14.88	**17.00**	19.00	35.00	
Pre-Service Evaluation Time:			**40.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	90.00	**120.00**	151.00	240.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49595	**Recommended Physician Work RVU: 14.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**40.00**	**33.00**	**7.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21813	000	17.61	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 25.0 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 49595	Top Key Reference CPT Code: 21813	2nd Key Reference CPT Code: **11005**
Median Pre-Service Time	70.00	70.00	60.00
Median Intra-Service Time	120.00	210.00	120.00
Median Immediate Post-service Time	40.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**230.00**	**310.00**	**265.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	20%	30%	30%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	40%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	40%	60%
Physical effort required	20%	30%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	20%	70%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	60%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	20%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	20%	80%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	40%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49595

We recommend a work RVU of 17.00, which is the survey median.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99232. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 20 minutes for 99232 has been added to the survey immediate postoperative time (total = 40 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49595 is similar to somewhat more than reference code 21813. Ref 2: The respondents indicated the intensity/complexity of survey code 49595 is somewhat more than reference code 11005.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49595	**Initial, Reduc, > 10cm**	**17.00**	**0.123**	**0.074**	**230**	**70**	**120**	**40**	~~**99232**~~

Other Code Comparison

Codes 61645 and 93591, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

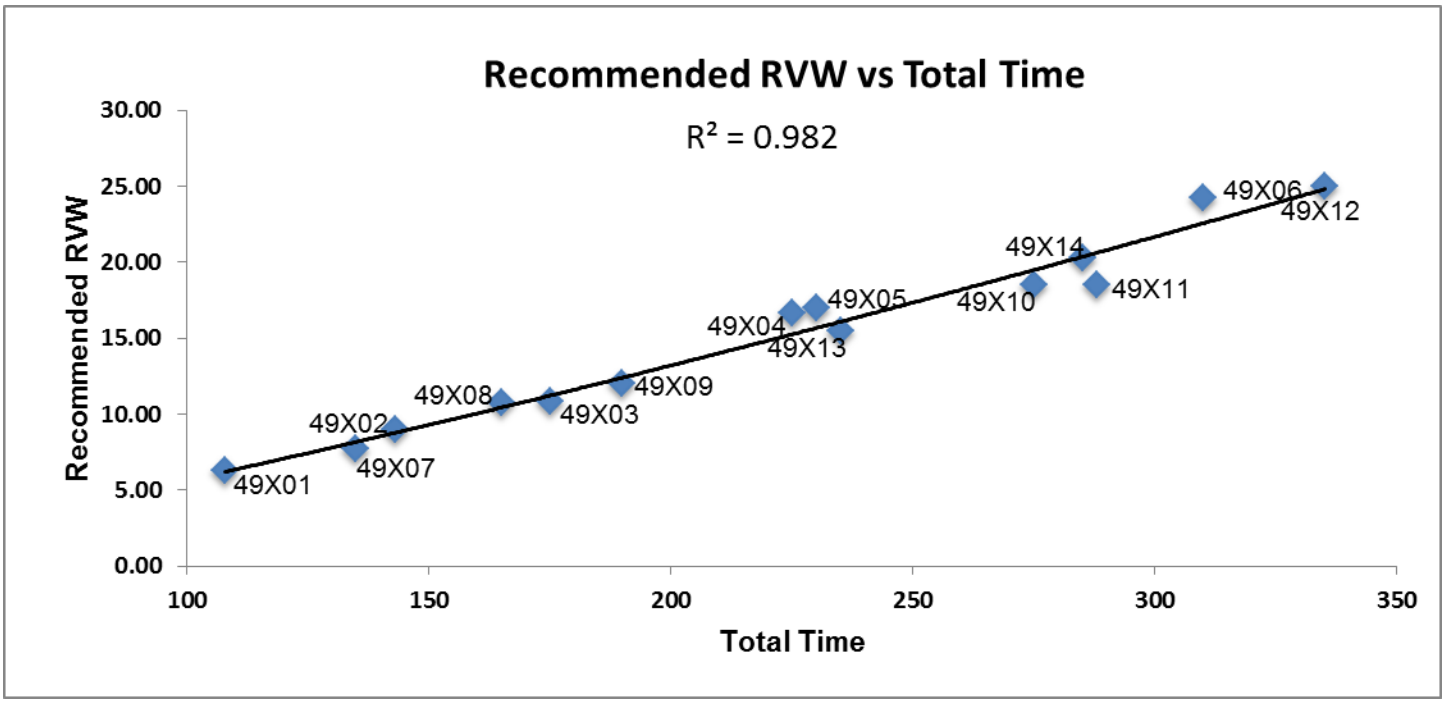
CPT Code: 49595

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	15.00	0.121	0.062	241	58	100	83	
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	230	70	120	40	~~99232~~
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	17.97	0.135	0.086	208	58	120	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



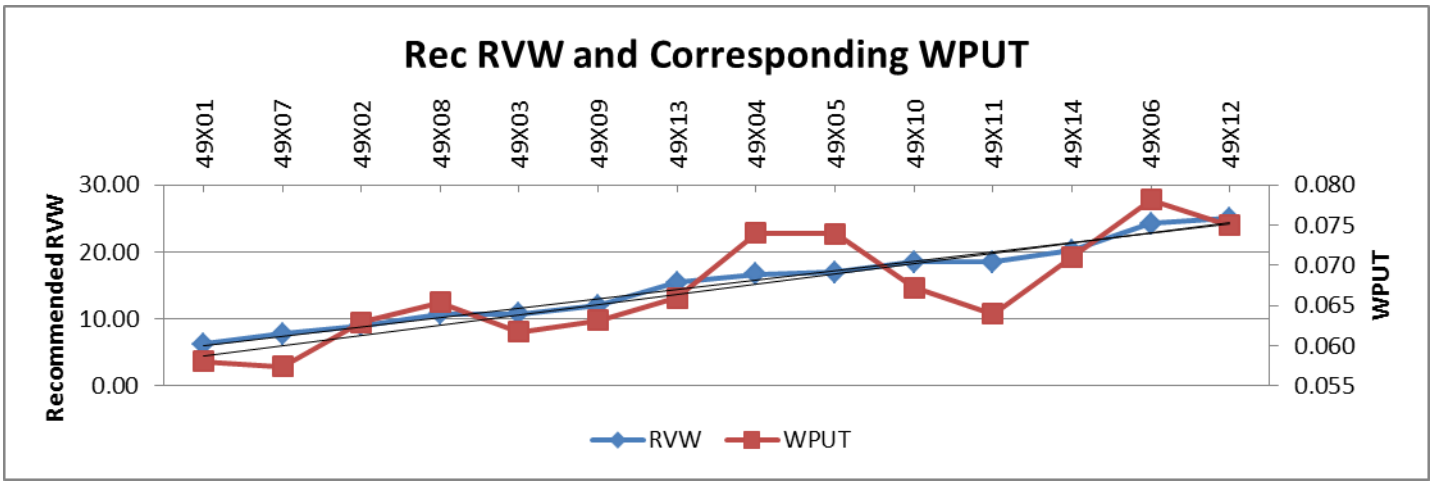
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

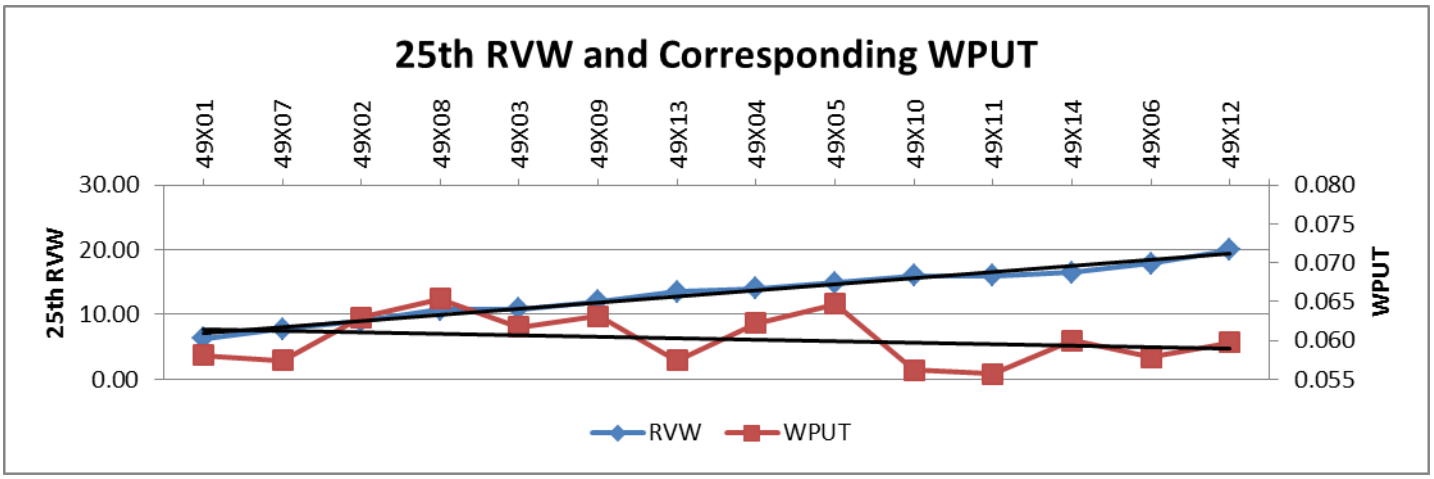
CPT	DESC		REC RVW	Total Time
49591	Initial, Reduc, < 3cm	25th	6.27	108
49613	Recurrent, Reduc, < 3cm	25th	7.75	135
49592	Initial, I/S, < 3cm	25th	9.00	143
49614	Recurrent, I/S, < 3cm	25th	10.79	165
49593	Initial, Reduc, 3-10cm	25th	10.80	175
49615	Recurrent, Reduc, 3-10cm	25th	12.00	190
49621	Parastomal, Reduc	median	15.50	235
49594	Initial, I/S, 3-10cm	median	16.65	225
49595	Initial, Reduc, > 10cm	median	17.00	230
49616	Recurrent, I/S, 3-10cm	median	18.50	275
49617	Recurrent, Reduc, > 10cm	median	18.53	288
49622	Parastomal, I/S	75th	20.25	285

49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3

minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49560 Repair initial incisional or ventral hernia; reducible 090
49570 Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure) 090
49585 Repair umbilical hernia, age 5 years or older; reducible 090
49590 Repair spigelian hernia 090
49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible 090
49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,191
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 1972 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 110 Percentage 5.02 %

Specialty Other Surgery Frequency 110 Percentage 5.02 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69

percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49596 Tracking Number C7 Original Specialty Recommended RVU: **24.24**
Presented Recommended RVU: **24.24**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **20.00**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old obese male with a prior laparotomy has developed incisional hernias with defects of varying sizes at multiple points. The defects have been increasing in size during follow-up with increasing symptoms. Physical exam reveals multiple tender and nonreducible incisional hernias. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 5% , Overnight stay-more than 24 hours 95%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 95%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The masses of the material incarcerated in the hernia are palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. As the hernia extends across the majority of the anterior abdominal wall, location for insertion of the needle/trocar is selected based on the prior surgical history and the safest location to avoid intra-abdominal injury. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies the entire anterior abdominal wall correlating with the extent of the prior laparotomy. Adhesions are divided sharply to free the anterior abdominal wall completely taking great care to avoid injury to the intestine. Each separate defect within the entire hernia defect contains adipose and intestinal components and requires a safe and effective clearance of tissue. The incarcerated/strangulated bowel, mesentery and omentum are carefully reduced

with dissection of the adhesions and sac to clear all the defects for repair. Care is taken to avoid injury to the incarcerated tissue. This requires manipulation both intra-abdominally with minimally invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced tissue is examined for viability and any inadvertent injury. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose all defects and enough surface for mesh overlap. The hernia sac is reduced and resected as needed to expose the fascial edges of the defect(s). The hernia defect is visualized. The defects are measured with a minimum craniocaudal length greater than 10 cm. Peritoneal flaps are created for placement of mesh. The fascial defect is approximated with sutures placed along the entirety of the defect. The appropriate size mesh is calculated after total defect length is documented. Adequate overlap of at least 5 cm in all directions is included in the calculation. A trocar is removed from the abdominal wall and the track is dilated to allow insertion of the large mesh into the peritoneal cavity. The mesh is oriented intra-abdominally. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing sutures and tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49596					
Sample Size:	1950	**Resp N:**	40			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**6.00**	11.00	70.00	
Survey RVW:	14.00	17.94	**20.00**	24.24	40.00	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	90.00	139.00	**160.00**	189.00	270.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**55.00**	99231x **0.00** 99232x **0.00** 99233x **1.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49596	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**160.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**25.00**	**33.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**55.00**	99231x **0.00** 99232x **0.00** 99233x **1.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61624	000	20.12	**RUC Time**

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 25.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 49596	Top Key Reference CPT Code: 11005	2nd Key Reference CPT Code: 61624
Median Pre-Service Time	70.00	60.00	95.00
Median Intra-Service Time	160.00	120.00	232.00
Median Immediate Post-service Time	25.00	30.00	35.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	55.0	55.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**310.00**	**265.00**	**362.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	20%	60%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	0%	90%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	10%	80%
Physical effort required	0%	10%	90%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	20%	80%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	44%	44%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	0%	89%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	0%	89%
Physical effort required	0%	11%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49596

We recommend a work RVU of 24.24, which is the survey 75th percentile. We believe the limited number of 0-day global codes that are familiar to general surgeons to be used on a reference service list hindered the ability for survey respondents to provide an accurate magnitude estimation of work.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day to monitor for postoperative complications including ileus, intestinal ischemia, and urinary retention. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant postoperative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49596 is somewhat/much more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49596 is somewhat/much more than reference code 61624.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49596	**Initial, I/S, > 10cm**	**24.24**	**0.127**	**0.078**	**310**	**70**	**160**	**25**	**99233**

Other Code Comparison

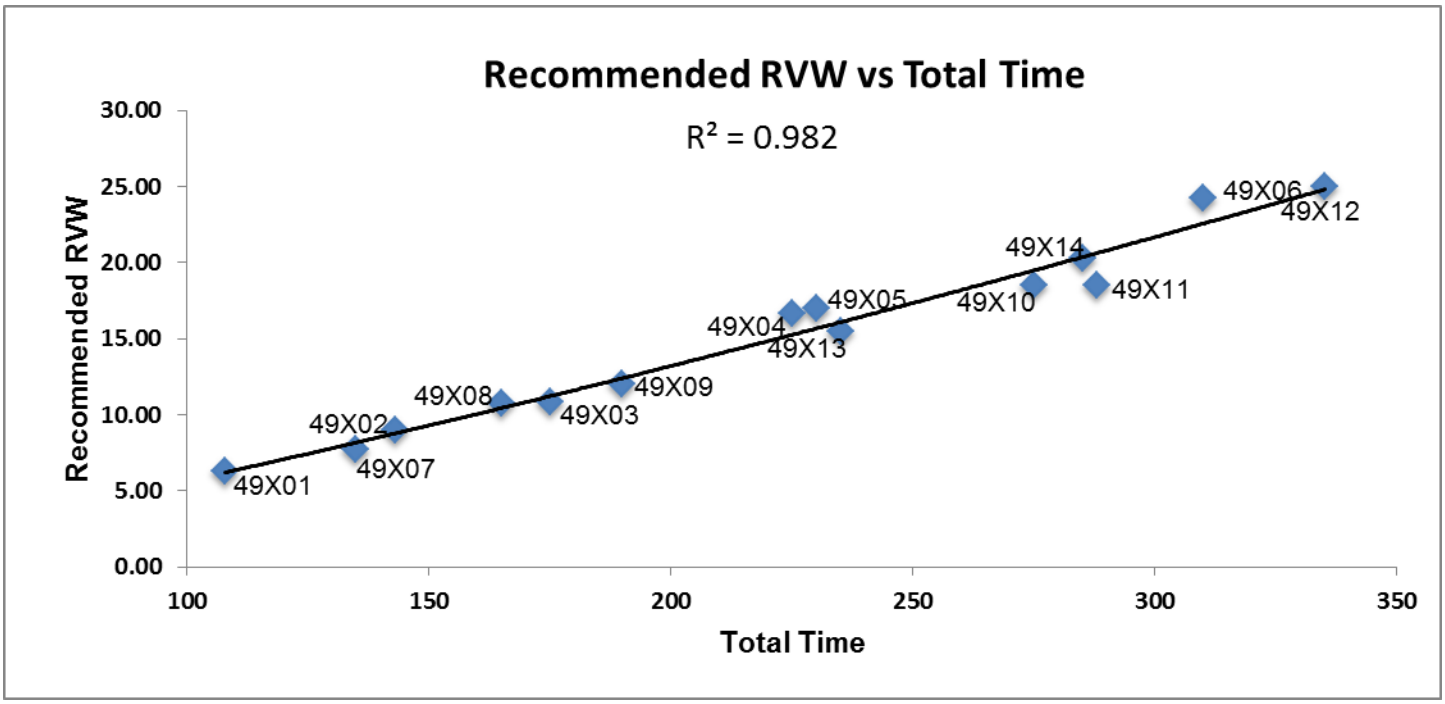
The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	**20.00**	0.192	0.097	207	55	92	60	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	**21.70**	0.148	0.097	223	58	135	30	
49596	**Initial, I/S, > 10cm**	**24.24**	**0.127**	**0.078**	**310**	**70**	**160**	**25**	**99233**
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	**25.00**	0.129	0.091	276	63	180	33	
33978	Removal of ventricular assist device; extracorporeal, biventricular	**25.00**	0.109	0.070	355	95	200	60	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



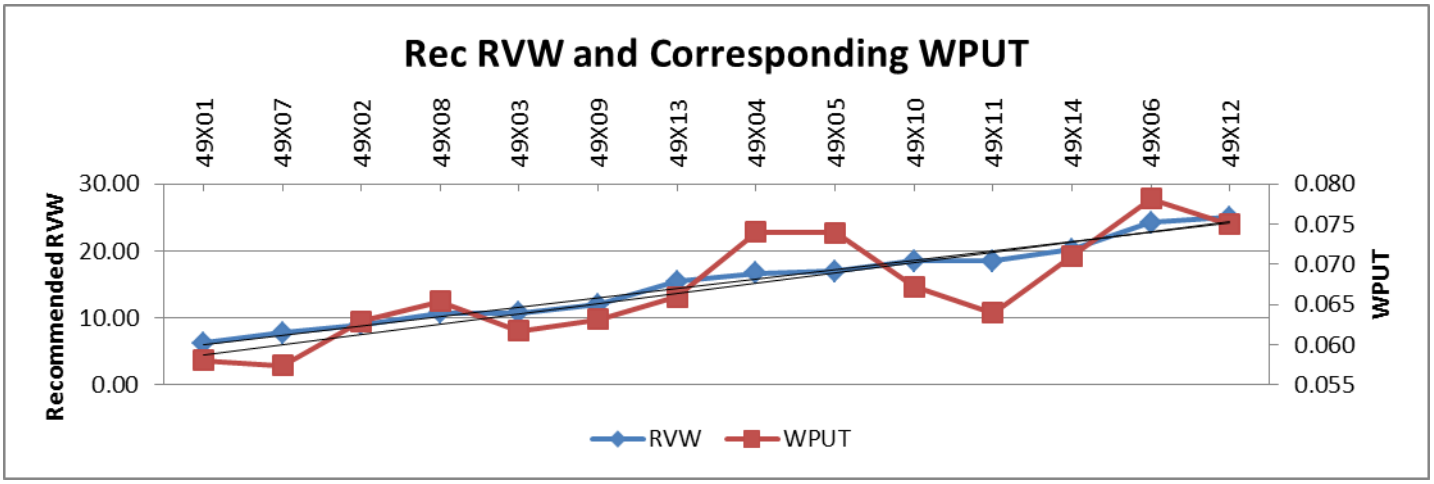
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

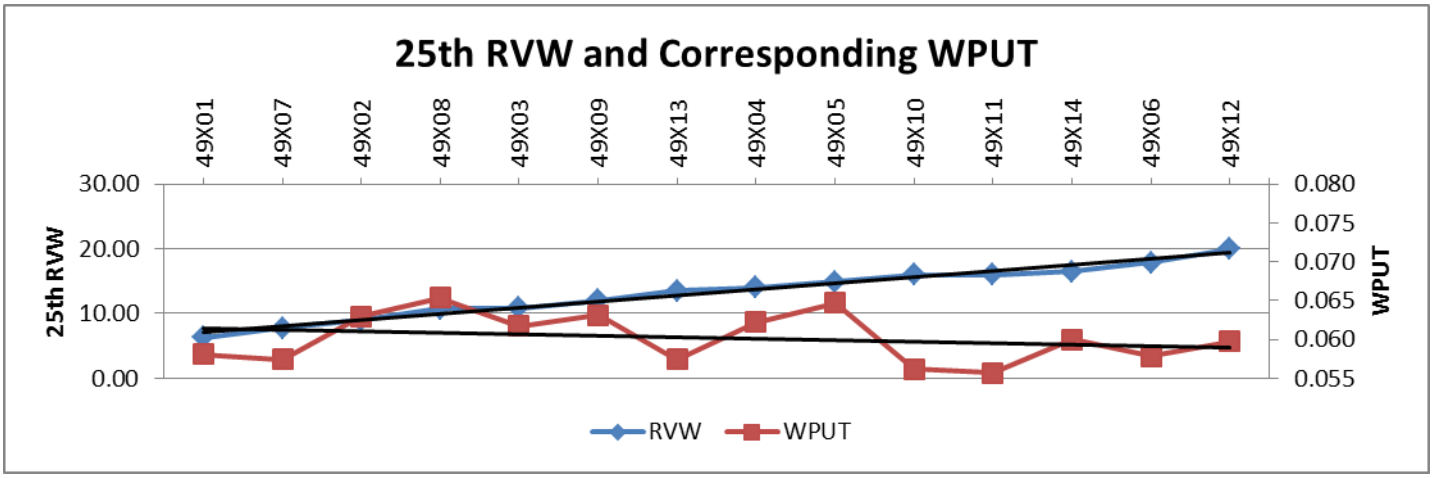
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**

49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the

IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49561 Repair initial incisional or ventral hernia; incarcerated or strangulated 090
49572 Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated 090
49587 Repair umbilical hernia, age 5 years or older; incarcerated or strangulated 090
49590 Repair spigelian hernia 090
49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 839
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery	Frequency 755	Percentage 89.98 %
Specialty Colorectal Surgery	Frequency 42	Percentage 5.00 %
Specialty Other Surgery	Frequency 42	Percentage 5.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49613 Tracking Number 49613 Original Specialty Recommended RVU: **7.75**
Presented Recommended RVU: **7.75**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **7.75**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male has a surgical history of a prior laparotomy with a resultant hernia in the incision. The prior hernia was repaired 5 years ago. He now has a bulge in the midepigastric area for 2 months that disappears when he lies down. Physical exam reveals a small recurrent reducible incisional hernia. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 93% , In the ASC 7%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 55% , Overnight stay-less than 24 hours 42% , Overnight stay-more than 24 hours 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 82%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. Adhesiolysis is performed to clear adhesions between omentum, small intestines and colon from the abdominal wall and prior mesh . The hernia defect is visualized. Adhesions to the abdominal wall are divided sharply to free the anterior abdominal wall completely. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia. Peritoneal flaps are created for placement of mesh. The fascial defect is approximated with sutures. The hernia defect is measured at less than 3 cm in diameter. A mesh is selected to provide adequate overlap of the hernia defect. A mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to

the abdominal wall utilizing sutures and/or tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. When safe to discharge patient to home, conduct final exam. Auscultate heart, lungs, and abdomen for bowel sounds. Assess for problems such as ileus, intestinal ischemia, and urinary retention. Assess pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing) with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49613					
Sample Size:	1950	**Resp N:**	41			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	3.00	5.00	**10.00**	20.00	64.00	
Survey RVW:	5.45	7.75	**11.00**	12.03	18.00	
Pre-Service Evaluation Time:			**30.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	30.00	45.00	**60.00**	63.00	100.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	49613	**Recommended Physician Work RVU: 7.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37225	000	11.75	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49013	000	8.35	**RUC Time**

CPT Descriptor Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52353	000	7.50	**RUC Time**	11,180

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52356	000	8.00	**RUC Time**	78,507

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 **% of respondents:** 17.0 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 49613	Top Key Reference CPT Code: 37225	2nd Key Reference CPT Code: **49013**
Median Pre-Service Time	55.00	38.00	50.00
Median Intra-Service Time	60.00	118.00	45.00
Median Immediate Post-service Time	20.00	30.00	60.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**135.00**	**186.00**	**155.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	29%	29%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	29%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	29%	14%	57%
Physical effort required	14%	14%	71%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	43%	29%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	20%	20%	60%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	0%	100%
Physical effort required	0%	20%	80%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	40%	0%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49613

We recommend a work RVU of 7.75, which is the survey 25th percentile. The typical patient will be discharged on the same day of the procedure.

Pre-service time

Evaluation package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Post-service time

Package time has been reduced so as to not exceed survey median data.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49613 is similar to reference code 37225. Ref 2: The respondents indicated the intensity/complexity of survey code 49613 is somewhat more than reference code 49013.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	**7.50**	0.101	0.056	133	53	60	20
49613	**Recurrent, Reduc, < 3cm**	**7.75**	**0.105**	**0.057**	**135**	**55**	**60**	**20**
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	**8.00**	0.110	0.060	133	53	60	20

Other Code Comparison

Codes 37211 and 43210, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

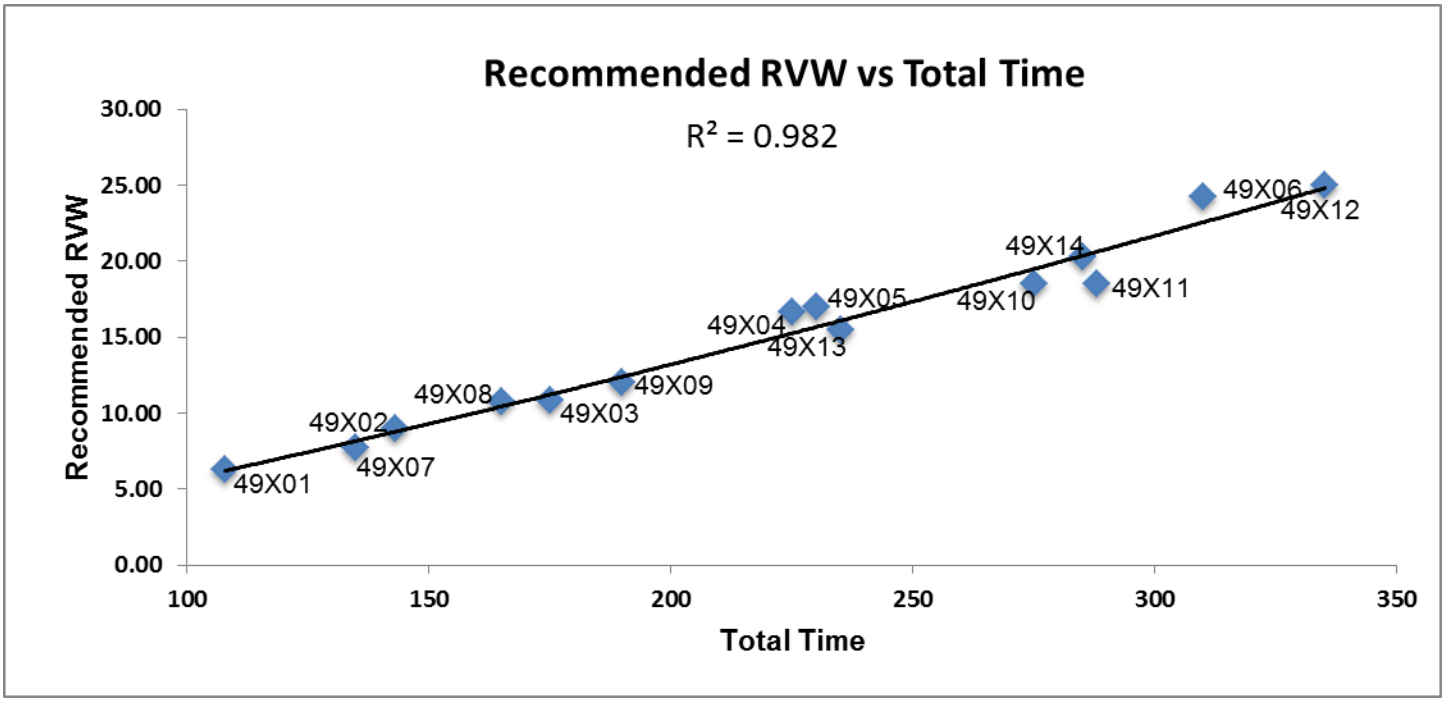
CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST

37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	**7.75**	0.105	0.061	128	38	60	30
49613	**Recurrent, Reduc, < 3cm**	**7.75**	**0.105**	**0.057**	**135**	**55**	**60**	**20**
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	**7.75**	0.100	0.052	148	58	60	30

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

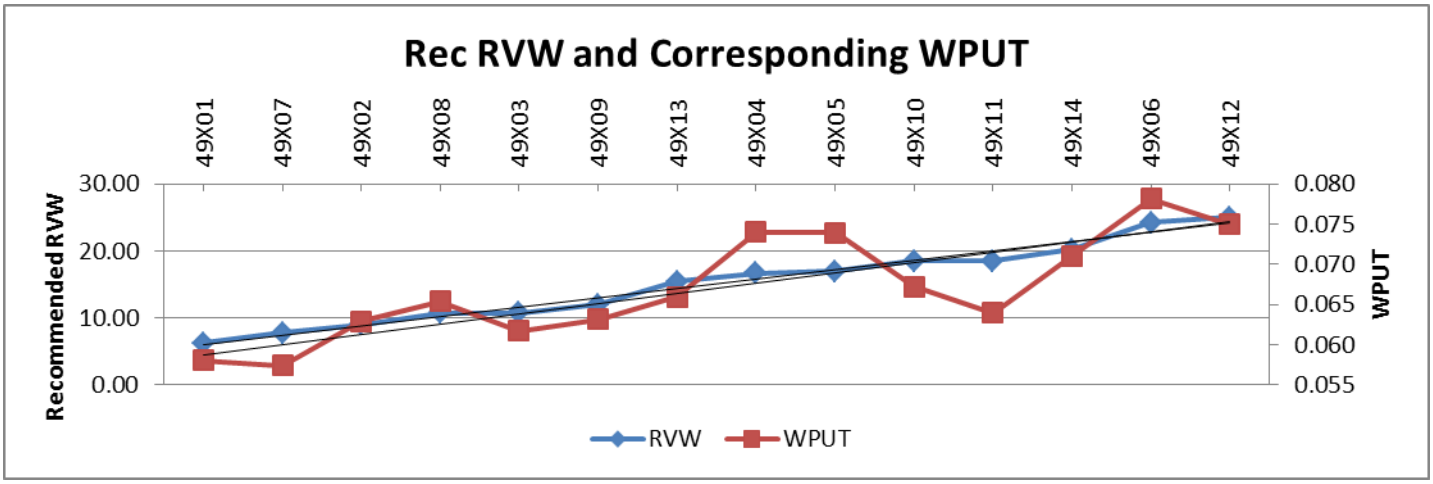


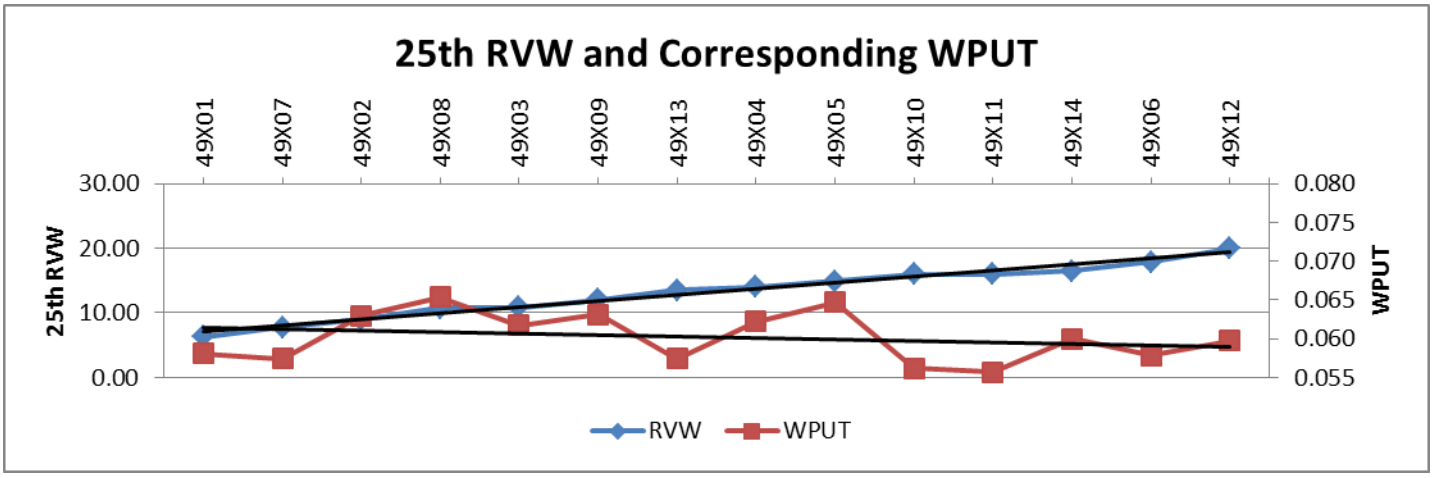
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize,

IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49565 Repair recurrent incisional or ventral hernia; reducible 090
49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,642
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 1478 Percentage 90.01 %

Specialty Colorectal Surgery Frequency 82 Percentage 4.99 %

Specialty Other Surgery Frequency 82 Percentage 4.99 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general

surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49614 Tracking Number C9 Original Specialty Recommended RVU: **10.79**
Presented Recommended RVU: **10.79**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **10.79**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male has a surgical history of a prior laparotomy with a resultant hernia in the incision. The prior hernia was repaired 5 years ago. He now has a small bulge in the midepigastric area for 2 months that previously disappeared when supine. The bulge is now irreducible and tender. Physical exam reveals a small recurrent incarcerated incisional hernia. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 2%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 25% , Overnight stay-less than 24 hours 55% , Overnight stay-more than 24 hours 20%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 97%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The masses of material incarcerated in the hernia are palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. The incarcerated/strangulated bowel, mesentery and omentum are carefully reduced with dissection of the adhesions from any previous mesh to expose and to clear the defect for repair. This requires manipulation both intra-abdominally with minimally invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced tissue is examined for viability and any inadvertent injury. The hernia sac is reduced and resected as needed to expose the fascial edges of the defect(s). The hernia defect is visualized.. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to

expose the posterior fascia. Peritoneal flaps are created for placement of mesh. The fascial defect is sutured. A mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing sutures and/or tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Fascial incisions from laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49614					
Sample Size:	1950	**Resp N:**	41			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	4.00	**10.00**	20.00	75.00	
Survey RVW:	7.00	10.79	**14.00**	17.50	23.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	45.00	65.00	**75.00**	90.00	120.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49614	**Recommended Physician Work RVU: 10.79**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**75.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21811	000	10.79	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 2 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 14.6 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 49614	Top Key Reference CPT Code: 21811	2nd Key Reference CPT Code: **11005**
Median Pre-Service Time	60.00	70.00	60.00
Median Intra-Service Time	75.00	120.00	120.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**165.00**	**220.00**	**265.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	17%	33%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	17%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	17%	67%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	17%	67%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	20%	60%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	0%	80%
Physical effort required	0%	80%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	40%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49614

We recommend a work RVU of 10.79, which is the survey 25th percentile median.

Pre-service time

Evaluation and scrub, dress, wait package time has been reduced so as to not exceed survey median data. Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99231. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (straightforward or low-complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 10 minutes for 99231 has been added to the survey immediate postoperative time (total = 30 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49614 is somewhat more than reference code 21811. Ref 2: The respondents indicated the intensity/complexity of survey code 49614 is somewhat more than reference code 11005.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic	**10.42**	0.104	0.074	141	31	90	20	

	injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit								
49614	**Recurrent, I/S, < 3cm**	**10.79**	**0.120**	**0.065**	**165**	**60**	**75**	**30**	**~~99231~~**
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	

Other Code Comparison

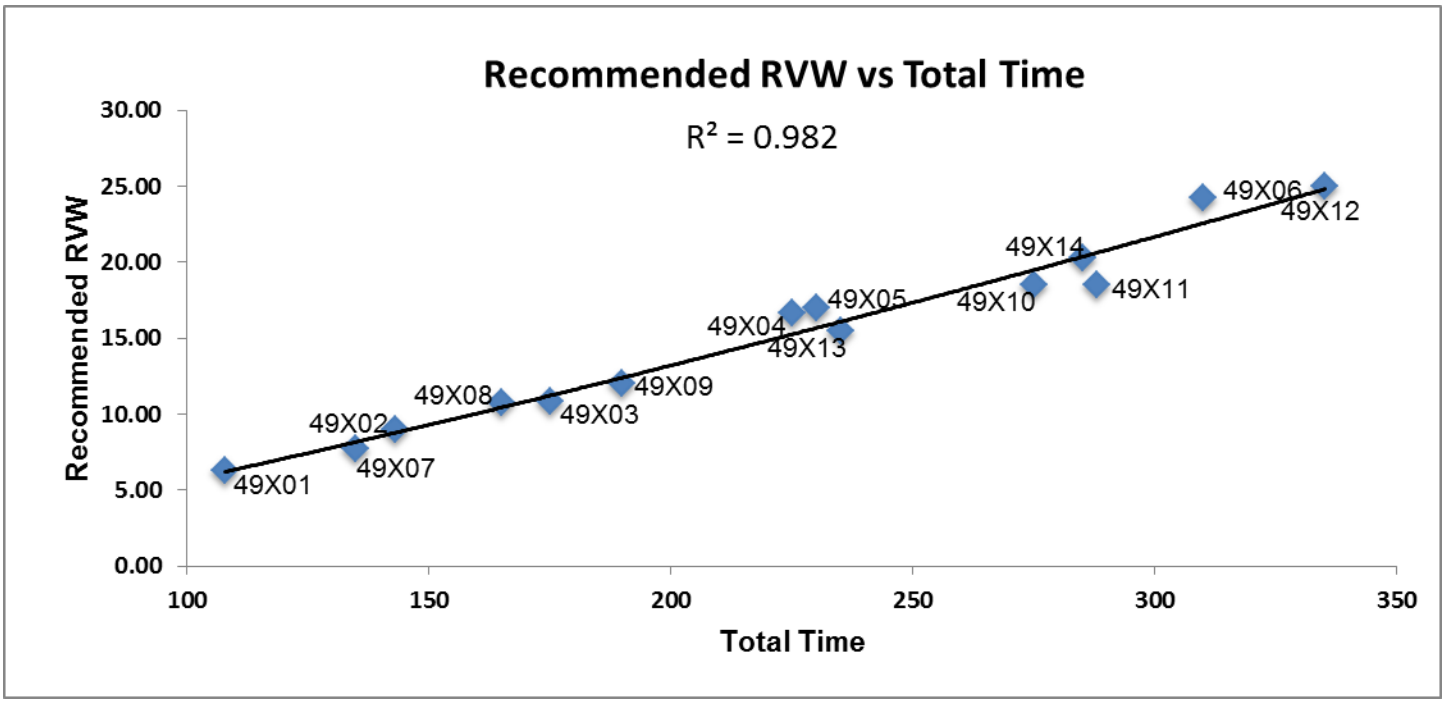
Codes 92920 and 92924, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**9.85**	0.126	0.078	127	29	68	30	
49614	**Recurrent, I/S, < 3cm**	**10.79**	**0.120**	**0.065**	**165**	**60**	**75**	**30**	**~~99231~~**
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**11.74**	0.125	0.082	143	29	84	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



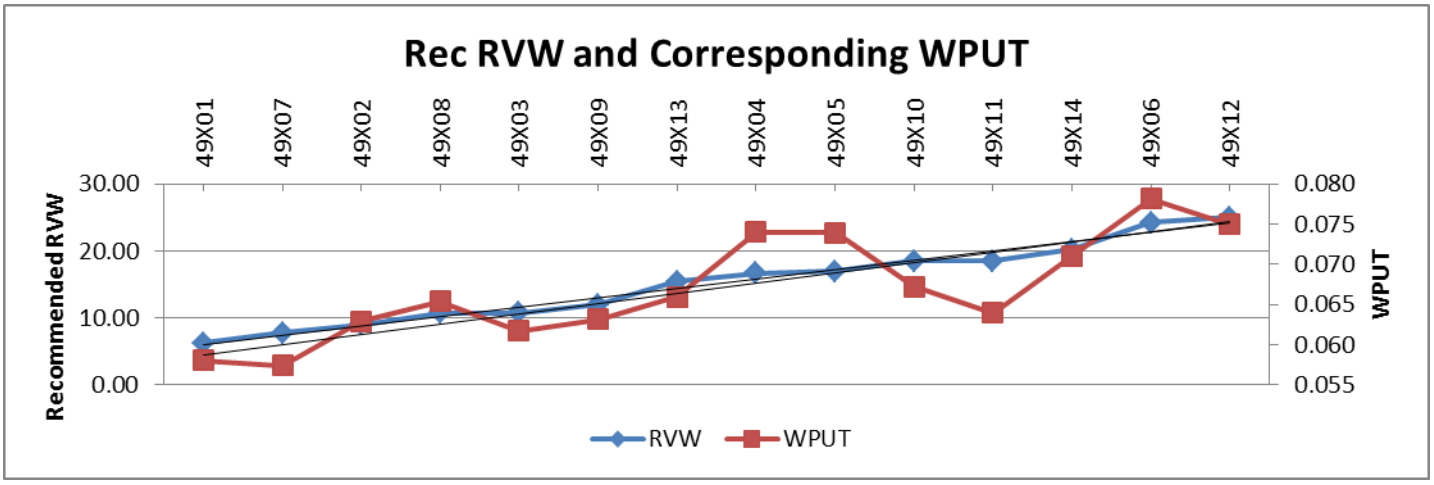
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

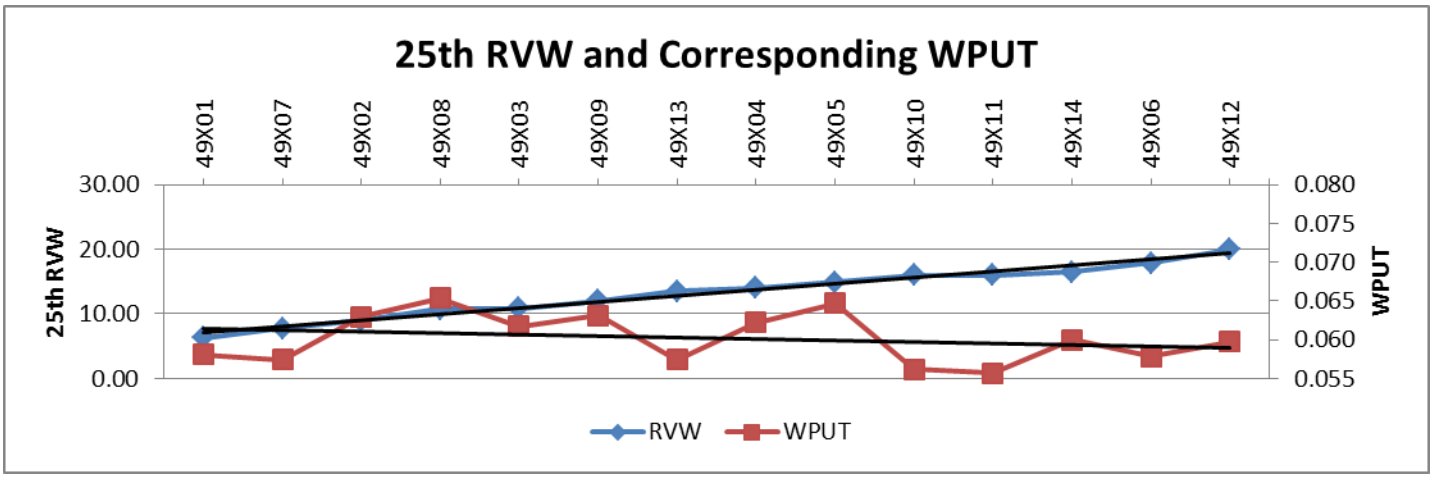
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**

49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49565 Repair recurrent incisional or ventral hernia; reducible 090
49657 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,050
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 945 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 53 Percentage 5.04 %

Specialty Other Surgery Frequency 53 Percentage 5.04 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the

Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49615 Tracking Number C10 Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **12.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **12.00**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with of a large bulge in midepigastric area that disappears when he lies down. His surgical history includes a prior laparotomy with resultant hernia that was repaired 5 years ago. Physical exam reveals a large recurrent reducible incisional hernia. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 16% , Overnight stay-less than 24 hours 51% , Overnight stay-more than 24 hours 33%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies approximately half of the anterior abdominal wall correlating with the extent of the prior laparotomy and hernia repair. Adhesions to the abdominal wall are divided sharply to free the anterior abdominal wall completely. The careful process of adhesiolysis is performed to clear adhesions from between omentum, small intestines and colon and the abdominal wall and prior mesh. Each separate defect within the entire hernia defect contains adipose and intestinal components and requires a safe and effective clearance of tissue. The hernia defect is visualized. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia. Peritoneal flaps are created for placement of mesh. The fascial defect is sutured the

entire length. A mesh is selected to provide adequate overlap of the hernia defect. A mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing sutures and/or tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to observation or general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital observation care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49615					
Sample Size:	1950	**Resp N:**	43			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**10.00**	21.00	78.00	
Survey RVW:	8.50	12.00	**15.00**	17.75	22.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	83.00	**100.00**	123.00	270.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49615	**Recommended Physician Work RVU: 12.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**100.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11006	000	13.10	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36906	000	10.42	**RUC Time**	14,028

CPT Descriptor 1 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 2 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 **% of respondents:** 16.2 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 16.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 49615	Top Key Reference CPT Code: 11006	2nd Key Reference CPT Code: **11005**
Median Pre-Service Time	60.00	65.00	60.00
Median Intra-Service Time	100.00	120.00	120.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	55.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**190.00**	**270.00**	**265.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	0%	71%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	14%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	0%	86%
Physical effort required	14%	43%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	43%	43%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	0%	86%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	14%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	14%	71%
Physical effort required	0%	43%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	14%	71%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49615

We recommend a work RVU of 12.00, which is the survey 25th percentile median.

Pre-service time

Evaluation and scrub, dress, wait package time has been reduced so as to not exceed survey median data. Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will stay overnight or longer and there will typically be a visit later on the same day of the procedure at a level of 99231. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (straightforward or low-complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intraservice time of 10 minutes for 99231 has been added to the survey immediate postoperative time (total = 30 min).

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49615 is somewhat more than reference code 11006. Ref 2: The respondents indicated the intensity/complexity of survey code 49615 is somewhat more than reference code 11005.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic	**10.42**	0.104	0.074	141	31	90	20	

	injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit								
49615	**Recurrent, Reduc, 3-10cm**	**12.00**	**0.102**	**0.063**	**190**	**60**	**100**	**30**	**~~99231~~**
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	

Other Code Comparison

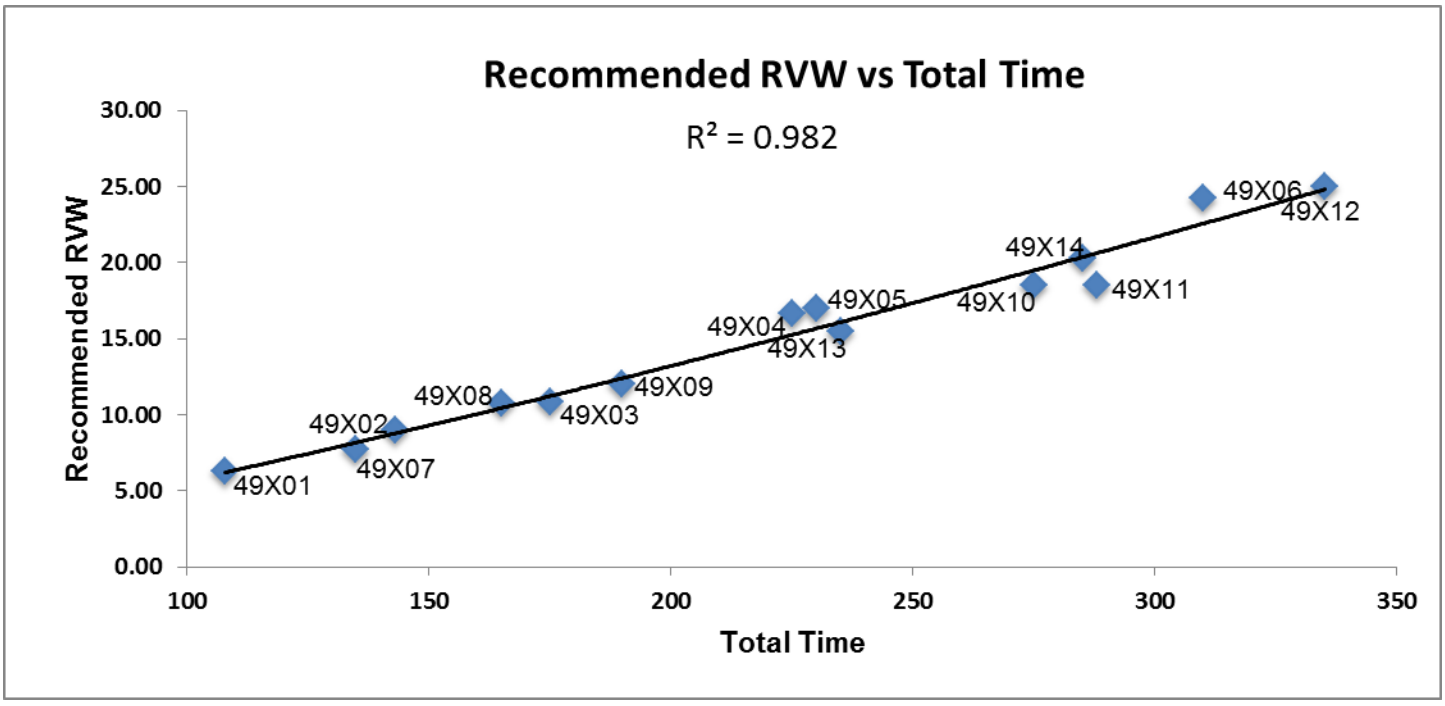
Codes 92924 and 37230, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**11.74**	0.125	0.082	143	29	84	30	
49615	**Recurrent, Reduc, 3-10cm**	**12.00**	**0.102**	**0.063**	**190**	**60**	**100**	**30**	**~~99231~~**
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	**13.55**	0.101	0.072	188	38	120	30	99291

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



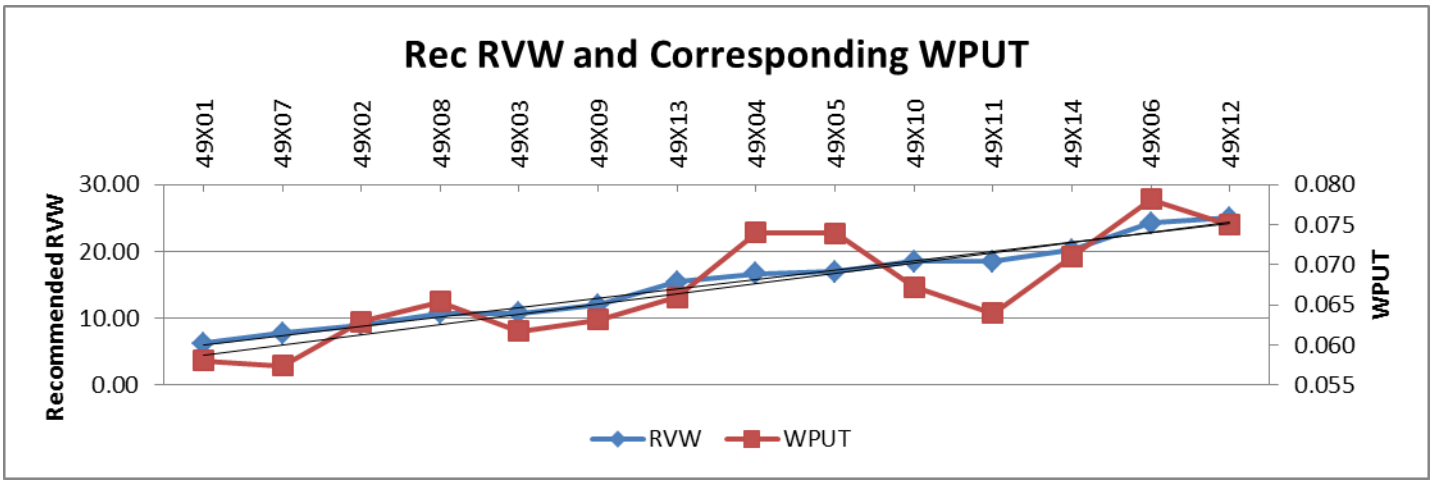
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

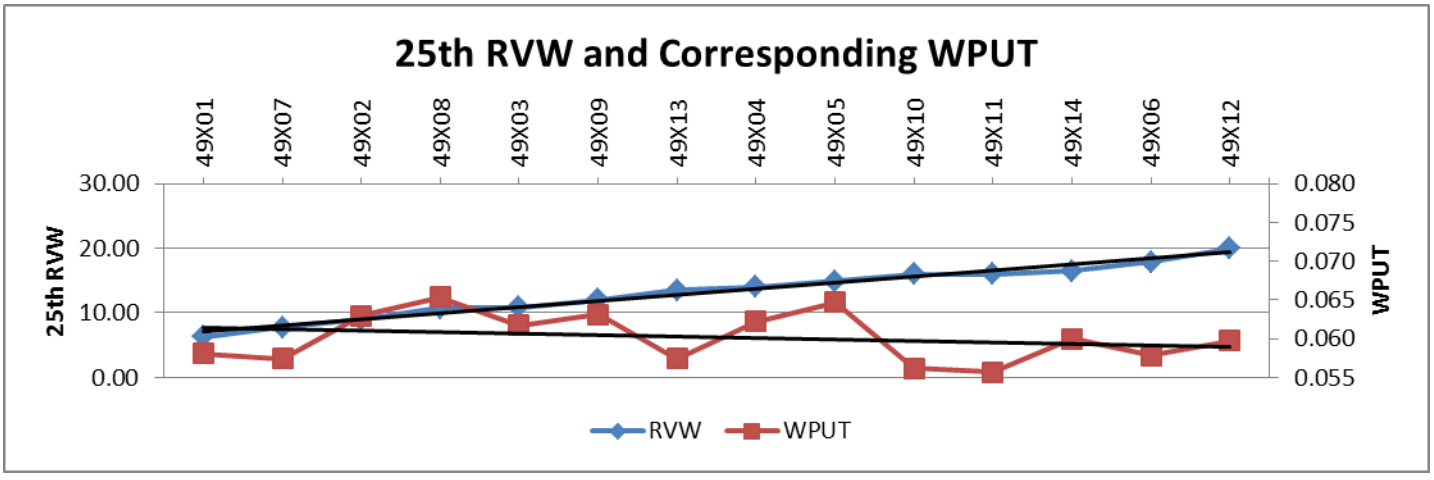
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**

49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

49565 Repair recurrent incisional or ventral hernia; reducible 090

49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible 090

49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,575
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 4118 Percentage 90.01 %

Specialty Colorectal Surgery Frequency 229 Percentage 5.00 %

Specialty Other Surgery Frequency 229 Percentage 5.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The

ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49616 Tracking Number C11 Original Specialty Recommended RVU: **18.50**
Presented Recommended RVU: **18.50**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **16.50**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size. Suddenly, the hernia is not reducible, and the mass is tender with severe, unremitting pain. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 7% , Overnight stay-less than 24 hours 35% , Overnight stay-more than 24 hours 58%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 95%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The masses of material incarcerated in the hernia are palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar in the left upper quadrant. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies approximately half of the anterior abdominal wall correlating with the extent of the prior laparotomy and hernia repair. The incarcerated/strangulated bowel, mesentery and omentum are carefully reduced with dissection of the adhesions from prior mesh to expose and to clear the defects for repair. This requires manipulation both intra-abdominally with minimally invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced

tissue is examined for viability and any inadvertent injury. The hernia sac is reduced and resected as needed to expose the fascial edges of the defect(s). The hernia defect(s) is visualized. Peritoneal flaps are created for placement of mesh The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior fascia. All of the defects are measured. The fascial defect is approximated with suture. A mesh is selected to provide adequate overlap of the hernia defect. A mesh is introduced into the peritoneal cavity through a trocar and is oriented. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing numerous sutures and/or tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49616					
Sample Size:	1950	**Resp N:**	43			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	3.00	**5.00**	13.00	130.00	
Survey RVW:	10.00	16.50	**18.50**	22.28	28.00	
Pre-Service Evaluation Time:			**40.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	70.00	120.00	**140.00**	190.00	360.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49616	**Recommended Physician Work RVU: 16.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**140.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**25.00**	**33.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	40.00	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33891	000	20.00	**RUC Time**

CPT Descriptor Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21813	000	17.61	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 25.5 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 20.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 49616	Top Key Reference CPT Code: 33891	2nd Key Reference CPT Code: **21813**
Median Pre-Service Time	70.00	110.00	70.00
Median Intra-Service Time	140.00	173.00	210.00
Median Immediate Post-service Time	25.00	40.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**275.00**	**323.00**	**310.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	18%	18%	36%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	36%	45%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	36%	45%
Physical effort required	9%	10%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	45%	18%	36%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	56%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	44%	56%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	22%	78%
Physical effort required	0%	44%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49616

We recommend a work RVU of 18.50, which is the survey median.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day to monitor for postoperative complications including ileus, intestinal ischemia, and urinary retention. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49616 is similar to somewhat more than reference code 33891. Ref 2: The respondents indicated the intensity/complexity of survey code 49616 is similar to somewhat more than reference code 21813.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49616	**Recurrent, I/S, 3-10cm**	**18.50**	**0.109**	**0.067**	**275**	**70**	**140**	**25**	**99232**

Other Code Comparison

The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

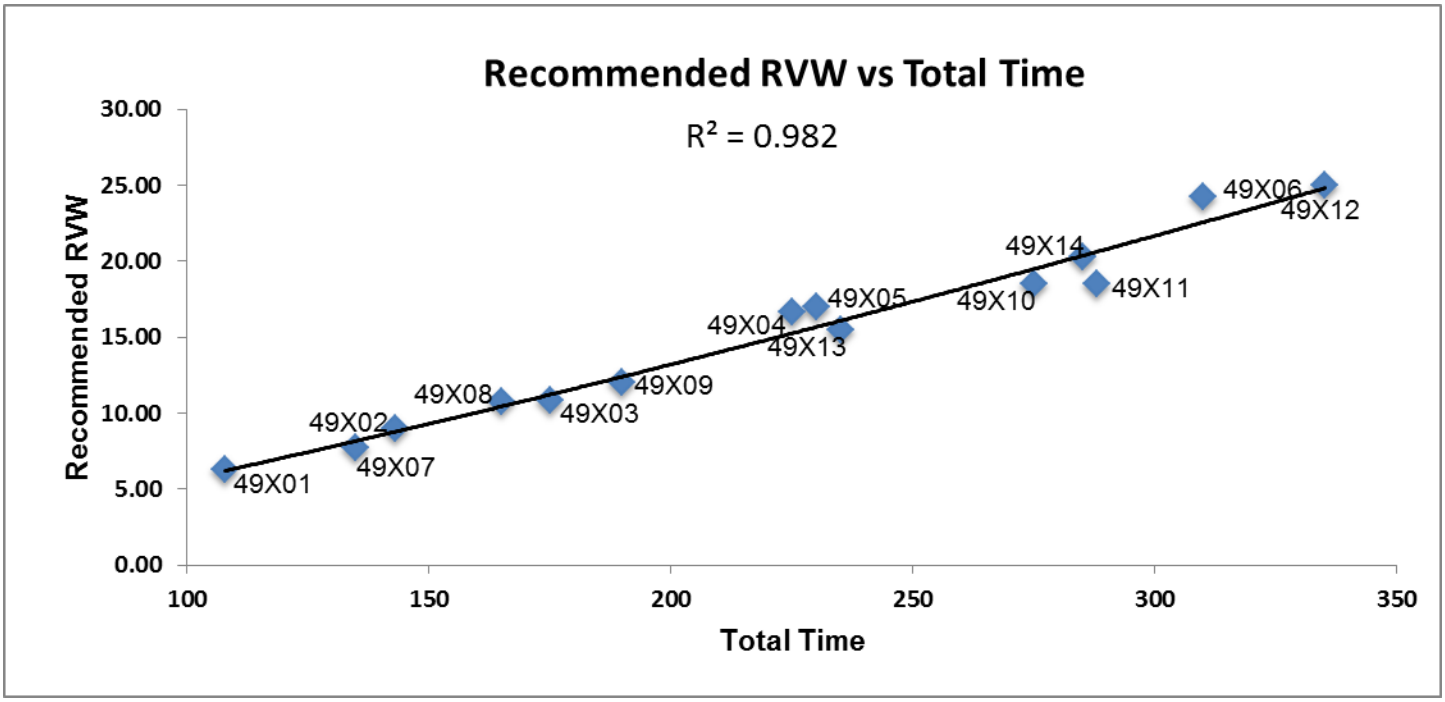
CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M

33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	**16.00**	0.108	0.064	250	60	90	30	99291
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	**17.97**	0.135	0.086	208	58	120	30	
49616	**Recurrent, I/S, 3-10cm**	**18.50**	**0.109**	**0.067**	**275**	**70**	**140**	**25**	**99232**
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	**20.00**	0.192	0.097	207	55	92	60	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	**21.70**	0.148	0.097	223	58	135	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



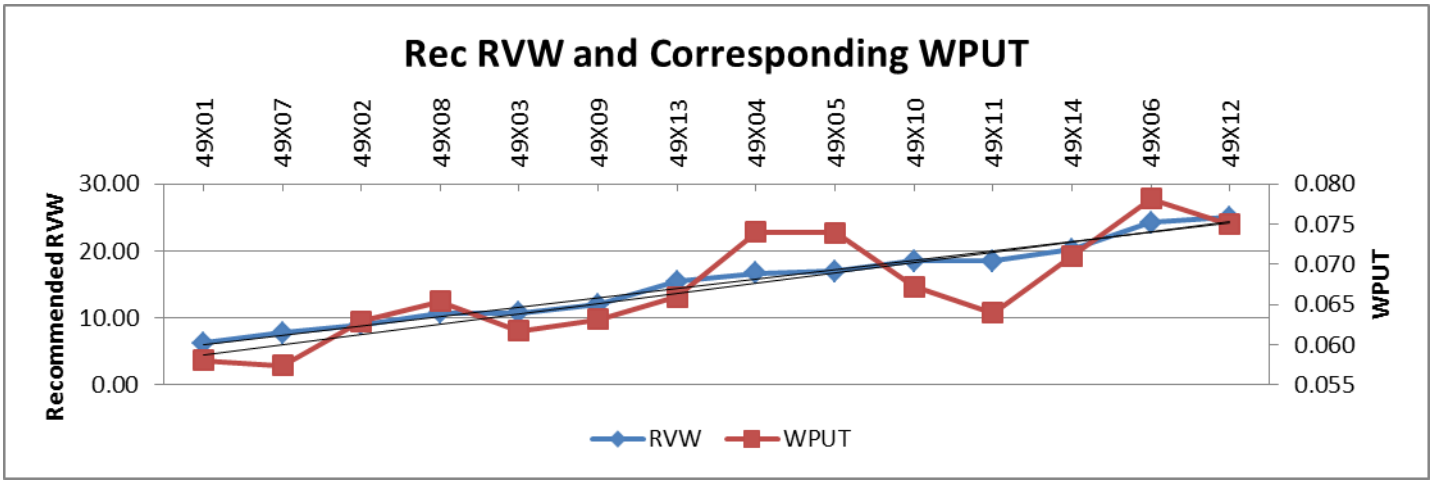
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

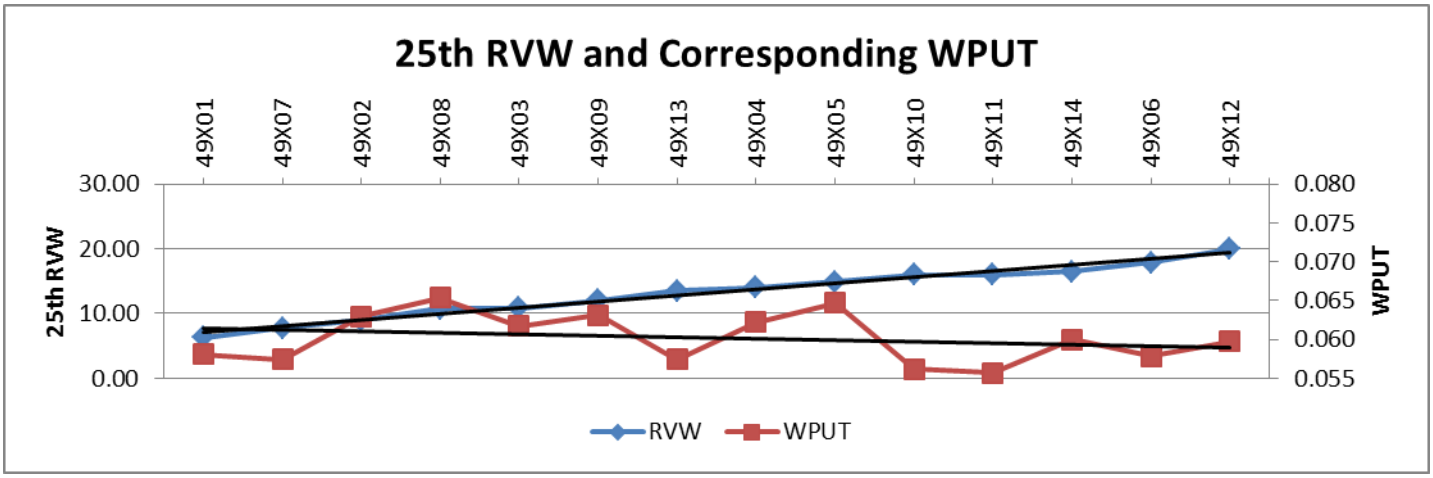
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**

49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial,** **I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent,** **I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial,** **I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent,** **I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the

IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49565 Repair recurrent incisional or ventral hernia; reducible 090
49657 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,676
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 3308 Percentage 89 %

Specialty Colorectal Surgery Frequency 184 Percentage 5.00 %

Specialty Other Surgery Frequency 184 Percentage 5.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the

request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49617 Tracking Number C12 Original Specialty Recommended RVU: **18.53**
Presented Recommended RVU: **18.53**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **16.97**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size but is reducible. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 2% , Overnight stay-less than 24 hours 29% , Overnight stay-more than 24 hours 69%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 90%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. As the hernia extends across the majority of the anterior abdominal wall, location for insertion of the needle/trocar is selected based on the prior surgical history and the safest location to avoid intra-abdominal injury. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, and in additional areas as needed, all under direct vision. A field of adhesions occupies the entire anterior abdominal wall correlating with the extent of the prior laparotomy and hernia repair. The careful process of adhesiolysis is performed to clear adhesions from between omentum, small intestines and colon and the abdominal wall and prior mesh. Each separate defect within the entire hernia defect contains adipose and intestinal components and requires a safe and effective clearance of tissue. The hernia defect is visualized. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose the posterior

fascia to include wide lateral clearance for adequate later mesh coverage. Peritoneal flaps are created for placement of mesh . The fascial defect is approximated with sutures placed along the entire length of the defect. The appropriate size mesh is calculated after total defect length is documented. Adequate overlap of at least 5 cm in all directions is included in the calculation. A trocar is removed from the abdominal wall and the track is dilated to allow insertion of the large mesh into the peritoneal cavity. The mesh is oriented intra-abdominally. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing multiple sutures and numerous tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Fascial incisions from laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49617					
Sample Size:	1950	**Resp N:**	42			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**7.00**	12.00	45.00	
Survey RVW:	11.50	16.03	**18.53**	22.00	40.00	
Pre-Service Evaluation Time:			**40.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	70.00	120.00	**150.00**	178.00	300.00	
Immediate Post Service-Time:	**28.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49617	**Recommended Physician Work RVU: 16.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**150.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**28.00**	**33.00**	**-5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11006	000	13.10	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 21.4 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 49617	Top Key Reference CPT Code: 11005	2nd Key Reference CPT Code: **11006**
Median Pre-Service Time	70.00	60.00	65.00
Median Intra-Service Time	150.00	120.00	120.00
Median Immediate Post-service Time	28.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	55.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**288.00**	**265.00**	**270.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	44%	44%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	33%	56%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	11%	89%
Physical effort required	0%	22%	78%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	33%	44%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	17%	17%	67%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	0%	100%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49617

We recommend a work RVU of 18.53, which is the survey median.

Pre-service time

Evaluation package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day to monitor for postoperative complications including ileus, intestinal ischemia, and urinary retention. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49617 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49617 is somewhat/much more than reference code 11006.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49617	**Recurrent, Reduc, > 10cm**	**18.53**	**0.101**	**0.064**	**288**	**70**	**150**	**28**	**99232**

Other Code Comparison

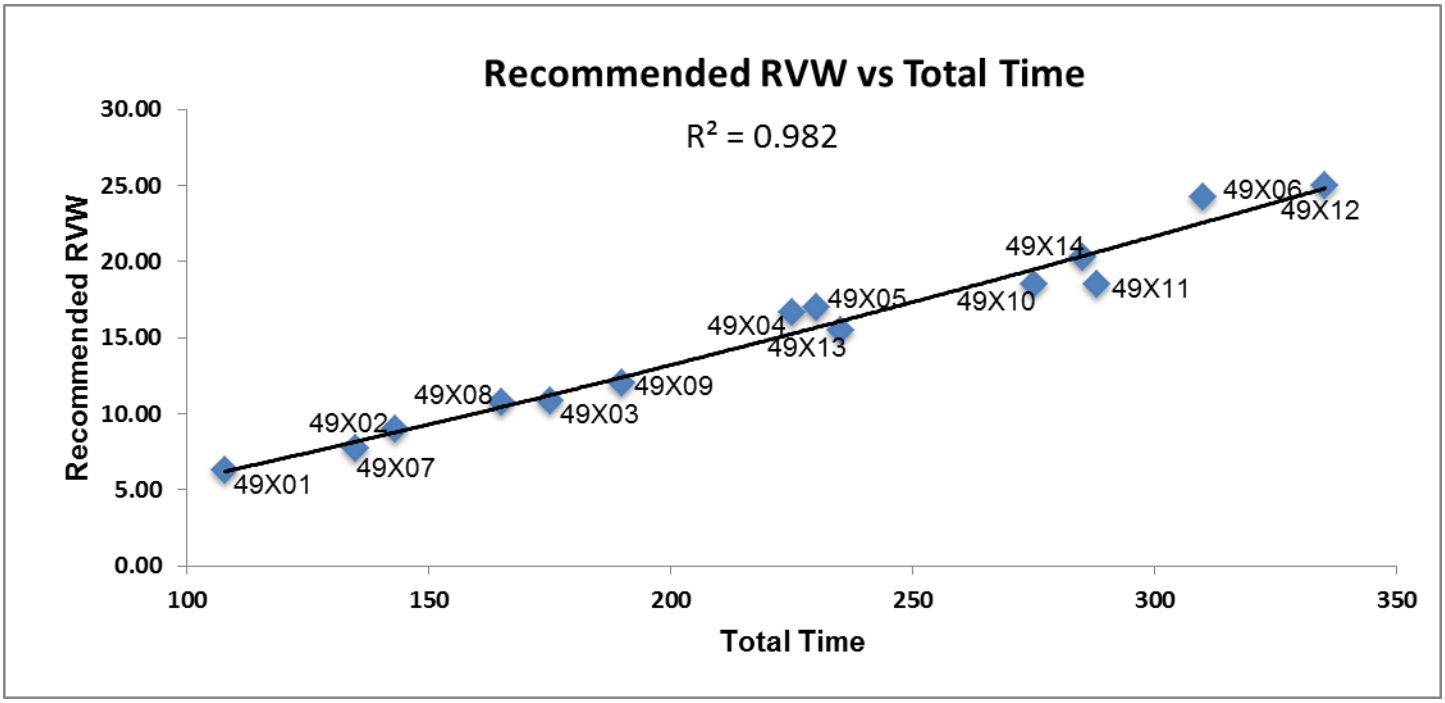
The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	**16.00**	0.108	0.064	250	60	90	30	99291
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	**17.97**	0.135	0.086	208	58	120	30	
49617	**Recurrent, Reduc, > 10cm**	**18.53**	**0.101**	**0.064**	**288**	**70**	**150**	**28**	**99232**
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	**20.00**	0.192	0.097	207	55	92	60	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	**21.70**	0.148	0.097	223	58	135	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

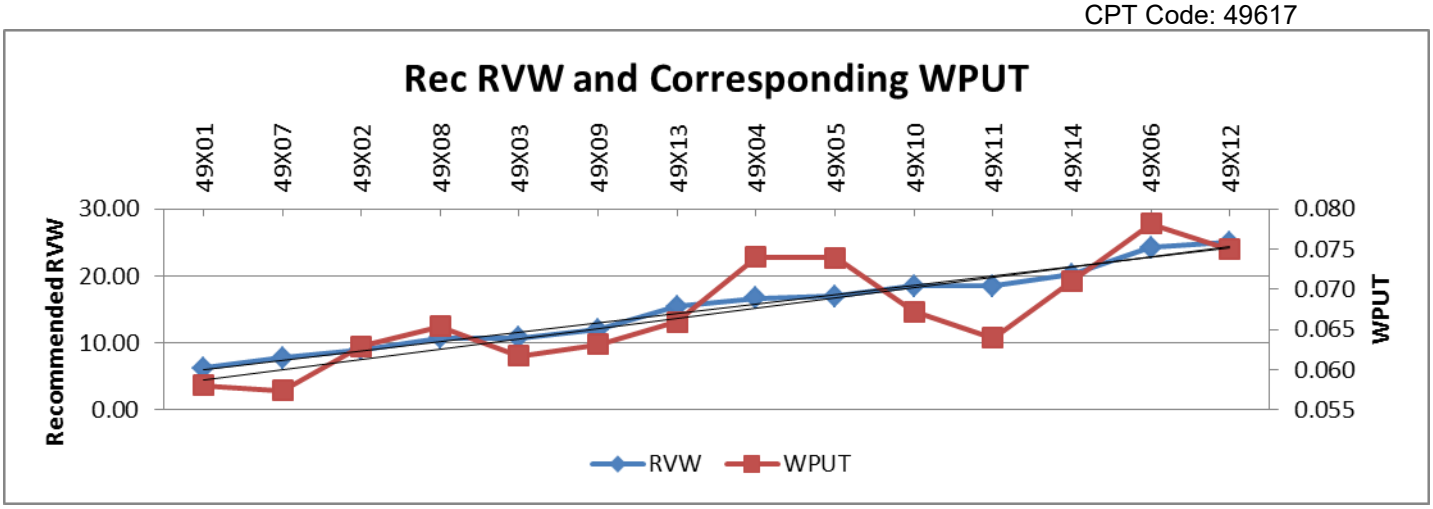


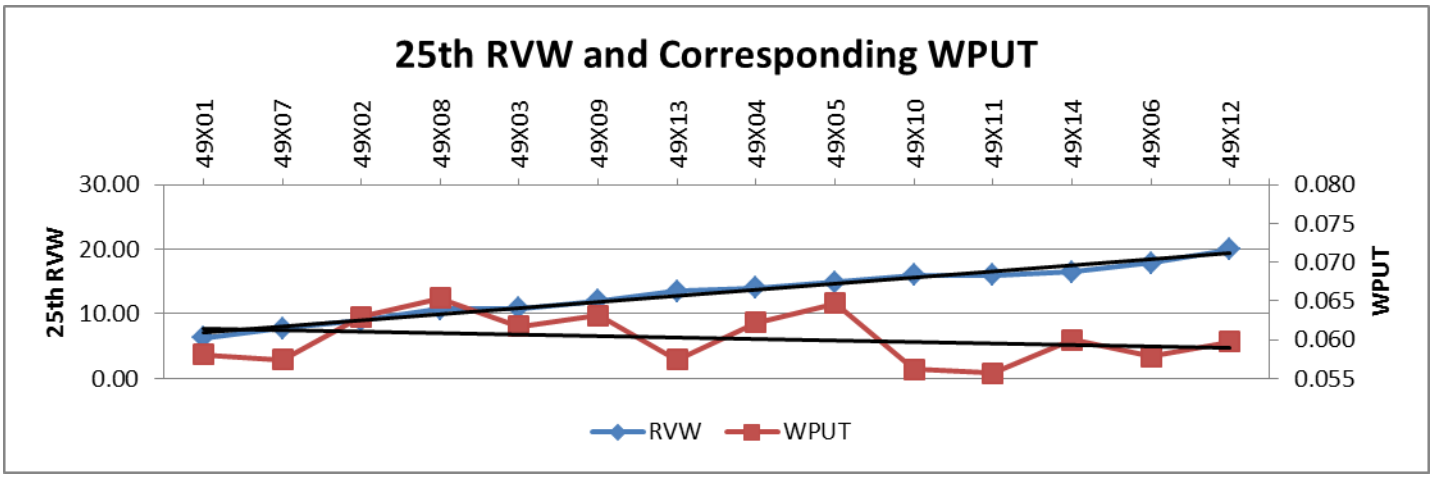
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?
As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an

ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49565 Repair recurrent incisional or ventral hernia; reducible 090
49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 622
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 560 Percentage 90.03 %

Specialty Colorectal Surgery Frequency 31 Percentage 4.98 %

Specialty Other Surgery Frequency 31 Percentage 4.98 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had

regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49618 Tracking Number C13 Original Specialty Recommended RVU: **25.00**
Presented Recommended RVU: **25.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **24.00**

CPT Descriptor: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size and is now tender and irreducible. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 5% , Overnight stay-more than 24 hours 95%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 95%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The masses of the material incarcerated in the hernia are palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. As the hernia extends across the majority of the anterior abdominal wall, location for insertion of the needle/trocar is selected based on the prior surgical history and the safest location to avoid intra-abdominal injury. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies the entire anterior abdominal wall correlating with the extent of the prior laparotomy. The careful process of adhesiolysis is performed to clear adhesions from between omentum, small intestines and colon and the abdominal wall and prior mesh. Each separate defect within the entire hernia defect contains adipose and intestinal components and requires a safe and effective clearance of tissue. The incarcerated/strangulated bowel, mesentery and

omentum are carefully reduced with dissection of the adhesions and sac to clear all the defects for repair. Care is taken to avoid injury to the incarcerated tissue. This requires manipulation both intra-abdominally with minimally invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced tissue is examined for viability and any inadvertent injury. The falciform ligament and preperitoneal fat are cleared from the abdominal wall fascia to expose all defects and enough surface for mesh overlap. The hernia sac is reduced and resected as needed to expose the fascial edges of the defect(s). The hernia defect is visualized. The defects are measured with a minimum craniocaudal length greater than 10 cm. Peritoneal flaps are created for placement of mesh. The fascial defect is approximated with sutures placed along the entirety of the defect. The appropriate size mesh is calculated after total defect length is documented. Adequate overlap of at least 5 cm in all directions is included in the calculation. A trocar is removed from the abdominal wall and the track is dilated to allow insertion of the large mesh into the peritoneal cavity. The mesh is oriented intra-abdominally. Insufflation is reduced to facilitate mesh conformity to the anterior abdominal wall. The mesh is secured to the abdominal wall utilizing sutures and tacks. The peritoneal flaps are then sutured over the mesh to protect it from the abdominal viscera. Completion camera survey is performed of the abdomen and contents to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49618					
Sample Size:	1950	**Resp N:**	42			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**5.00**	10.00	40.00	
Survey RVW:	15.50	20.00	**24.00**	25.00	45.00	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	100.00	175.00	**180.00**	208.00	330.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**55.00**	99231x **0.00** 99232x **0.00** 99233x **1.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49618	**Recommended Physician Work RVU: 24.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**55.00**	99231x **0.00** 99232x **0.00** 99233x **1.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61624	000	20.12	**RUC Time**

CPT Descriptor Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21813	000	17.61	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 38.0 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 23.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 49618	Top Key Reference CPT Code: 61624	2nd Key Reference CPT Code: **21813**
Median Pre-Service Time	70.00	95.00	70.00
Median Intra-Service Time	180.00	232.00	210.00
Median Immediate Post-service Time	30.00	35.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	55.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**335.00**	**362.00**	**310.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	19%	25%	50%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	25%	69%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	19%	69%
Physical effort required	0%	13%	88%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	25%	69%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	40%	30%	30%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	40%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	60%	40%
Physical effort required	0%	60%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	40%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49618

We recommend a work RVU of 25.00, which is the survey 75th percentile. We believe the limited number of 0-day global codes that are familiar to general surgeons to be used on a reference service list hindered the ability for survey respondents to provide an accurate magnitude estimation of work.

Pre-service time

Evaluation package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day to monitor for postoperative complications including ileus, intestinal ischemia, and urinary retention. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant post-operative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49618 is somewhat more than reference code 61624. Ref 2: The respondents indicated the intensity/complexity of survey code 49618 is similar to somewhat more than reference code 21813.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49618	**Recurrent, I/S, > 10cm**	**25.00**	**0.117**	**0.075**	**335**	**70**	**180**	**30**	**99233**

Other Code Comparison

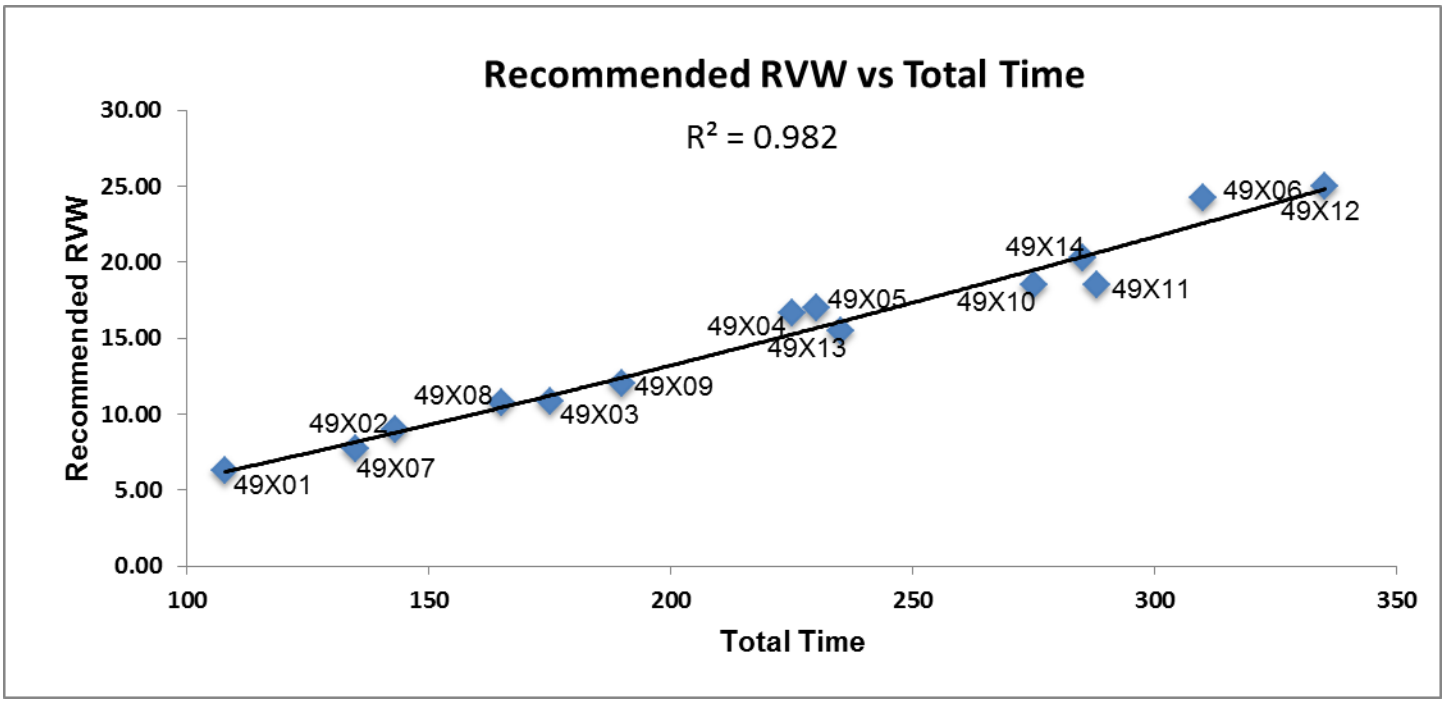
The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	**21.70**	0.148	0.097	223	58	135	30	
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	**25.00**	0.129	0.091	276	63	180	33	
49618	**Recurrent, I/S, > 10cm**	**25.00**	**0.117**	**0.075**	**335**	**70**	**180**	**30**	**99233**
33978	Removal of ventricular assist device; extracorporeal, biventricular	**25.00**	0.109	0.070	355	95	200	60	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



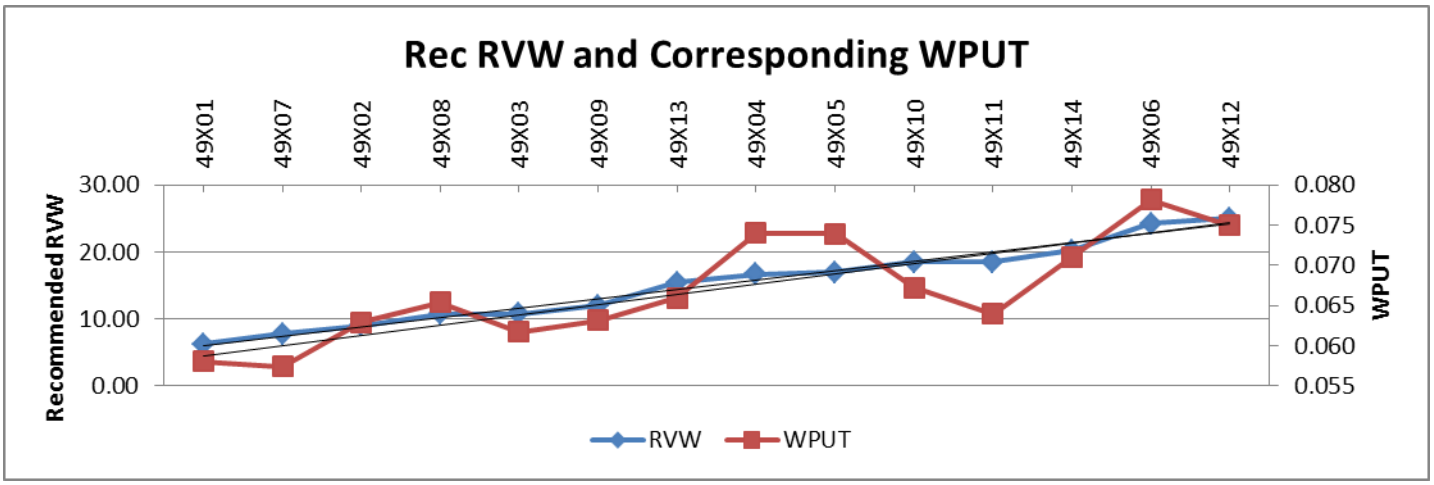
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

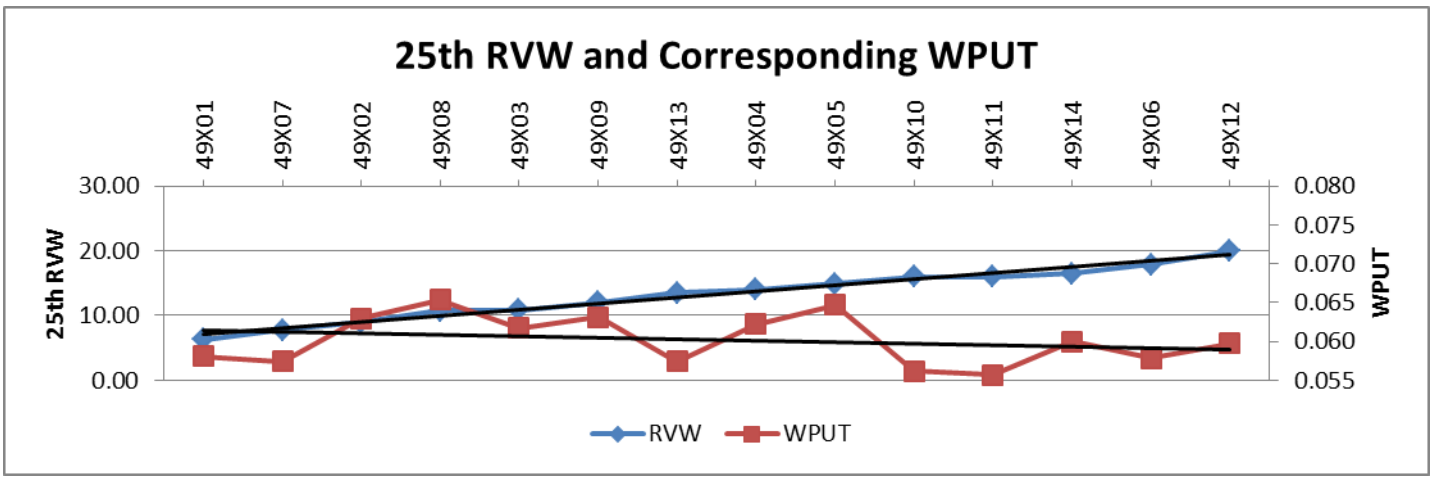
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**

49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation.

The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49565 Repair recurrent incisional or ventral hernia; reducible 090
49657 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 473
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 426 Percentage 90.06 %

Specialty Colorectal Surgery Frequency 24 Percentage 5.07 %

Specialty Other Surgery Frequency 24 Percentage 5.07 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69

percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49621 Tracking Number C14 Original Specialty Recommended RVU: **15.50**
Presented Recommended RVU: **15.50**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **14.24**

CPT Descriptor: Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with history of rectal cancer with subsequent abdominoperineal resection and end colostomy presents with a worsening bulge around his stoma when coughing, pain and discomfort around the stoma, and difficulty keeping the stoma appliance in place due to leakage. CT scan revealed small bowel in the hernia sac. He undergoes parastomal hernia repair with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 5% , Overnight stay-less than 24 hours 28% , Overnight stay-more than 24 hours 67%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 73%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The palpable edge of the hernia defect(s) and sites of the proposed skin incisions are marked with cooperation of patient. Location for a new and revised stoma site is marked if needed. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg). Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The colostomy appliance is removed and the areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. A temporary closure suture is placed in the stoma to avoid evacuation during the procedure. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies the anterior abdominal wall surrounding the stoma site. Adhesions around the stoma are taken down sharply avoiding injury to the stoma intestinal component traversing the abdominal wall. The careful process of adhesiolysis is performed to clear adhesions from between omentum, small intestines and colon and the abdominal wall and prior mesh when present. The hernia sac is identified and adhesions within the sac are also taken down. The hernia sac is excised. The hernia defect is narrowed with suture taking care to leave the appropriate size fascial defect for the colostomy yet avoiding an opportunity for intestinal contents to traverse the abdominal wall beside it

allowing a recurrence. The colon proximal to the colostomy is mobilized to ensure that there is no tension on the colostomy. The appropriate size of mesh is inserted into the peritoneal cavity and fashioned around the colostomy to cover the hernia defect also avoiding narrowing of the colostomy or offering space for material to traverse the abdominal wall beside it allowing a recurrence. Sutures and tacks are used to anchor the mesh to the anterior abdominal wall. Completion laparoscopic survey is performed to inspect for bleeding and visceral injury. Irrigation is performed as necessary. Hemostasis is assured. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference. The temporary closure suture is removed from the stoma. Patency of the stoma is assessed prior to completion of the procedure.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: A stoma appliance is applied. Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49621					
Sample Size:	1300	**Resp N:**	39			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**2.00**	5.00	10.00	
Survey RVW:	8.35	13.50	**15.50**	18.00	28.00	
Pre-Service Evaluation Time:			**42.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	70.00	99.00	**120.00**	155.00	280.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49621	**Recommended Physician Work RVU: 14.24**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**25.00**	**33.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11005	000	14.24	**RUC Time**

CPT Descriptor Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21813	000	17.61	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 **% of respondents:** 17.9 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 17.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 49621	Top Key Reference CPT Code: 11005	2nd Key Reference CPT Code: **21813**
Median Pre-Service Time	70.00	60.00	70.00
Median Intra-Service Time	120.00	120.00	210.00
Median Immediate Post-service Time	25.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	20.0	55.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**235.00**	**265.00**	**310.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	29%	71%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	0%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	14%	86%
Physical effort required	0%	29%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	43%	57%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	43%	43%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	29%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	57%	43%
Physical effort required	0%	57%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	57%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49621

We recommend a work RVU of 15.50, which is the survey median.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (straightforward or low-complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49621 is similar to somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49621 is similar to somewhat more than reference code 21813.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49621	**Parastomal, Reduc**	**15.50**	**0.107**	**0.066**	**235**	**70**	**120**	**25**	**99231**

Other Code Comparison

The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

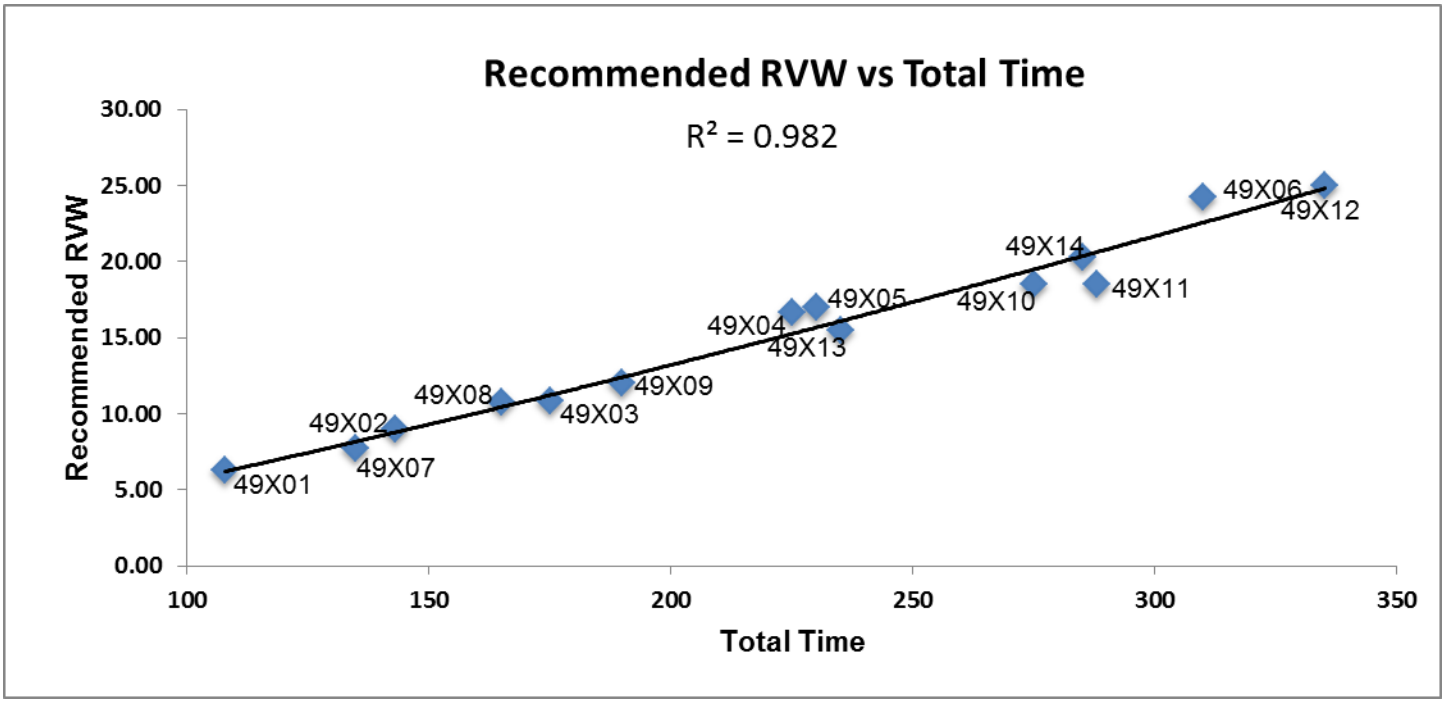
CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
61645	Percutaneous arterial transluminal mechanical	**15.00**	0.121	0.062	241	58	100	83	

	thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)								
49621	**Parastomal, Reduc**	**15.50**	**0.107**	**0.066**	**235**	**70**	**120**	**25**	**99231**
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	**16.00**	0.108	0.064	250	60	90	30	99291
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	**16.11**	0.108	0.059	275	95	120	60	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



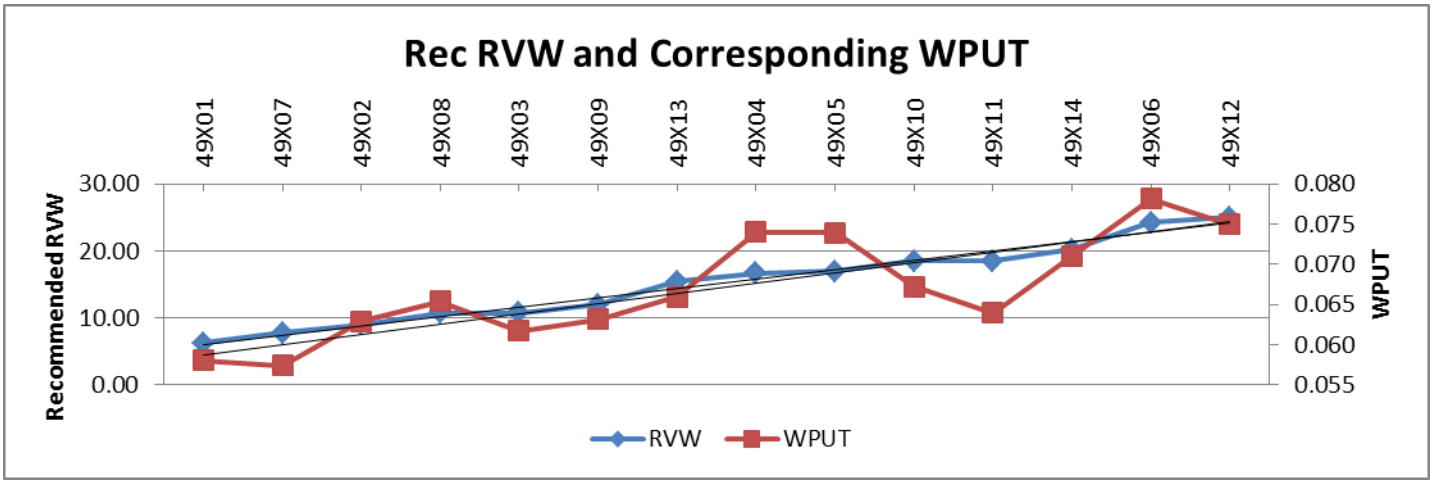
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

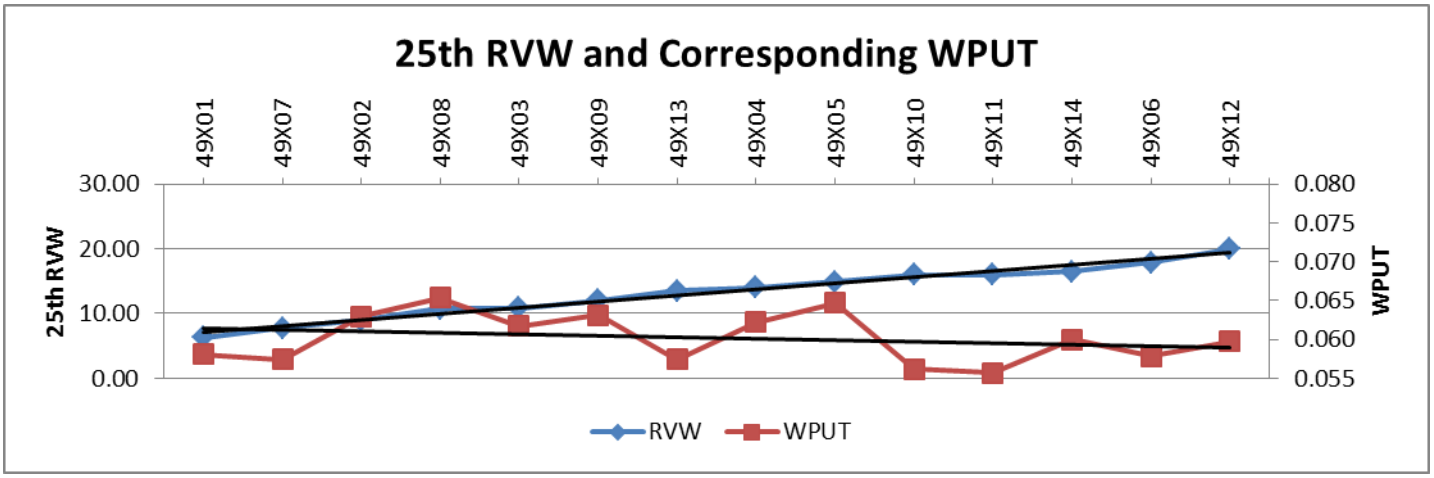
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**
49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**

49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To

emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	1.60	0.084	0.053	0.089	0.053	30	5	15	10				
49591	Initial, Reduc, < 3cm	6.27	0.113	0.058	0.079	0.058	108	43	45	20				same day
49613	Recurrent, Reduc, < 3cm	7.75	0.105	0.057	0.075	0.057	135	55	60	20				same day
49592	Initial, I/S, < 3cm	9.00	0.123	0.063	0.085	0.059	153	53	60	20			1	overnight
49614	Recurrent, I/S, < 3cm	10.79	0.120	0.065	0.088	0.062	175	60	75	20			1	overnight
49593	Initial, Reduc, 3-10cm	10.80	0.101	0.062	0.076	0.058	185	55	90	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	12.00	0.102	0.063	0.078	0.060	200	60	100	20			1	overnight
49621	Parastomal, Reduc	15.50	0.107	0.066	0.089	0.066	235	70	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	16.65	0.121	0.074	0.097	0.068	245	65	120	20		1		overnight
49595	Initial, Reduc, > 10cm	17.00	0.123	0.074	0.098	0.068	250	70	120	20		1		overnight
49616	Recurrent, I/S, 3-10cm	18.50	0.109	0.067	0.093	0.067	275	70	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	18.53	0.101	0.064	0.086	0.064	288	70	150	28		1		inpatient
99284	Moderate MDM	2.74	0.106	0.069	0.098	0.069	40	6	22	12				
49622	Parastomal, I/S	20.25	0.113	0.071	0.099	0.071	285	70	150	25		1		inpatient
99285	High MDM	4.00	0.115	0.073	0.080	0.073	55	9	30	16				
49596	Initial, I/S, > 10cm	24.24	0.127	0.078	0.113	0.078	310	70	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	25.00	0.117	0.075	0.104	0.075	335	70	180	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

49560 Repair initial incisional or ventral hernia; reducible 090
49565 Repair recurrent incisional or ventral hernia; reducible 090
49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible 090
49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible 090
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy YYY
49999 Unlisted procedure, abdomen, peritoneum and omentum YYY
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 709
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 638 Percentage 89.98 %

Specialty Colorectal Surgery Frequency 35 Percentage 4.93 %

Specialty Other Surgery Frequency 35 Percentage 4.93 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49622 Tracking Number C15 Original Specialty Recommended RVU: **20.25**
Presented Recommended RVU: **20.25**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **18.00**

CPT Descriptor: Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with history of rectal cancer, colon resection and sigmoid colostomy presents with a worsening parastomal hernia associated with pain. The hernia cannot be reduced and a CT scan indicates incarcerated small bowel loops in the parastomal hernia sac. He undergoes parastomal hernia repair with placement of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Overnight stay-less than 24 hours 3% , Overnight stay-more than 24 hours 95%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 82%

Description of Pre-Service Work: Results of preadmission testing (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed, the patient's medication regimen has remained the same, the patient has no new allergies, and the patient has not undergone any recent procedures. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The mass of incarcerated material occupying the hernia is palpated obscuring the edge of the hernia defect(s). The sites of the proposed skin incisions are marked with cooperation of patient. A site for a new and revised stoma site is marked if needed. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic/robotic equipment and mesh. Assistance is provided in transfer of the patient from gurney to operating table. Monitor/assist with positioning of patient, including padding and securing patient to table that will adjust throughout procedure (eg, reverse Trendelenburg) Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic/robotic equipment. The colostomy appliance is removed and the areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. A temporary closure suture is placed in the stoma site to avoid evacuation during the procedure. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Abdominal access is obtained and a safe pneumoperitoneum is created with placement of a needle/trocar. The camera is inserted and safe entry is verified. Additional trocars are placed in the lateral abdomen, under direct vision. A large field of adhesions occupies the anterior abdominal wall surrounding the stoma site. Adhesions around the stoma are taken down sharply avoiding injury to the stoma intestinal component traversing the abdominal wall. The careful process of adhesiolysis is performed to clear adhesions from between omentum, small intestines and colon and the abdominal wall and prior mesh when present. Reduction of the incarcerated material is initiated. This requires manipulation both intra-abdominally with minimally invasive instrumentation and extra-abdominally with palpation and pressure applied to the abdominal wall to reduce the incarcerated contents. The reduced tissue is examined for viability and

any inadvertent injury. The hernia sac is identified and adhesions within the sac are taken down and the hernia sac is excised. The hernia defect is narrowed with suture taking care to leave the appropriate size fascial defect for the colostomy yet avoiding an opportunity for intestinal contents to traverse the abdominal wall beside it allowing a recurrence. The colon proximal to the colostomy is mobilized to ensure that there is no tension on the colostomy. The appropriate size of mesh is inserted into the peritoneal cavity and fashioned around the colostomy to cover the hernia defect also avoiding narrowing of the colostomy or offering space for material to traverse the abdominal wall beside it allowing a recurrence. Sutures and tacks are used to anchor the mesh to the anterior abdominal wall to secure the mesh. Completion laparoscopic survey is performed to inspect for bleeding and visceral injury and perform a final viability assessment of the material once incarcerated in the hernia sac. Irrigation is performed as necessary. Hemostasis is assured. Fascial incisions for laparoscopic ports larger than 1 cm are closed with a suture passer. Skin incisions are closed according to surgeon preference. The temporary closure suture is removed from the stoma. Patency of the stoma is assessed prior to completion of the procedure.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: A stoma appliance is applied. Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with nursing staff.

Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitor for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49622					
Sample Size:	1300	**Resp N:**	39			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**2.00**	3.00	10.00	
Survey RVW:	10.08	16.00	**18.00**	20.25	34.00	
Pre-Service Evaluation Time:			**50.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	90.00	123.00	**150.00**	180.00	360.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49622	**Recommended Physician Work RVU: 18.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**150.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**25.00**	**33.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21813	000	17.61	**RUC Time**

CPT Descriptor Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33891	000	20.00	**RUC Time**

CPT Descriptor Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 25.6 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 15.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 49622	Top Key Reference CPT Code: 21813	2nd Key Reference CPT Code: **33891**
Median Pre-Service Time	70.00	70.00	110.00
Median Intra-Service Time	150.00	210.00	173.00
Median Immediate Post-service Time	25.00	30.00	40.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**285.00**	**310.00**	**323.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	90%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	10%	90%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	30%	70%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	10%	90%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	33%	50%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	50%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	33%	50%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	33%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49622

We recommend a work RVU of 20.25, which is the survey 75th percentile. We believe a lack of recent or five year experience in conjunction with a challenging reference list may have resulted in an underestimation of work. One-third of the respondents had not performed this procedure in the past 12 months. The 12 month median experience was 2 and the 5 year median experience was only 6. This is not a common procedure. Incarcerated parastomal hernias can prove very challenging to identify which segment is the stoma component should remain penetrating through the abdominal wall and which loops are bowel that should be reduced adding to the complexity of the procedure.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.
Laparoscopic/robotic anterior abdominal hernia repair positioning time: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents.. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment. The survey median positioning time reflects the time for this procedure for these activities.

Postoperative E/M visit later on the day of surgery

The typical patient will be admitted and a visit will occur later on the same day. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49622 is similar to somewhat more than reference code 21813. Ref 2: The respondents indicated the intensity/complexity of survey code 49622 is similar to somewhat more than reference code 33891.

MPC Code Comparison

MPC code 37244 has the highest RVW for the set of 0-day global codes.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	166	31	90	45	
49622	**Parastomal, I/S**	**20.25**	**0.113**	**0.071**	**285**	**70**	**150**	**25**	**99232**

Other Code Comparison

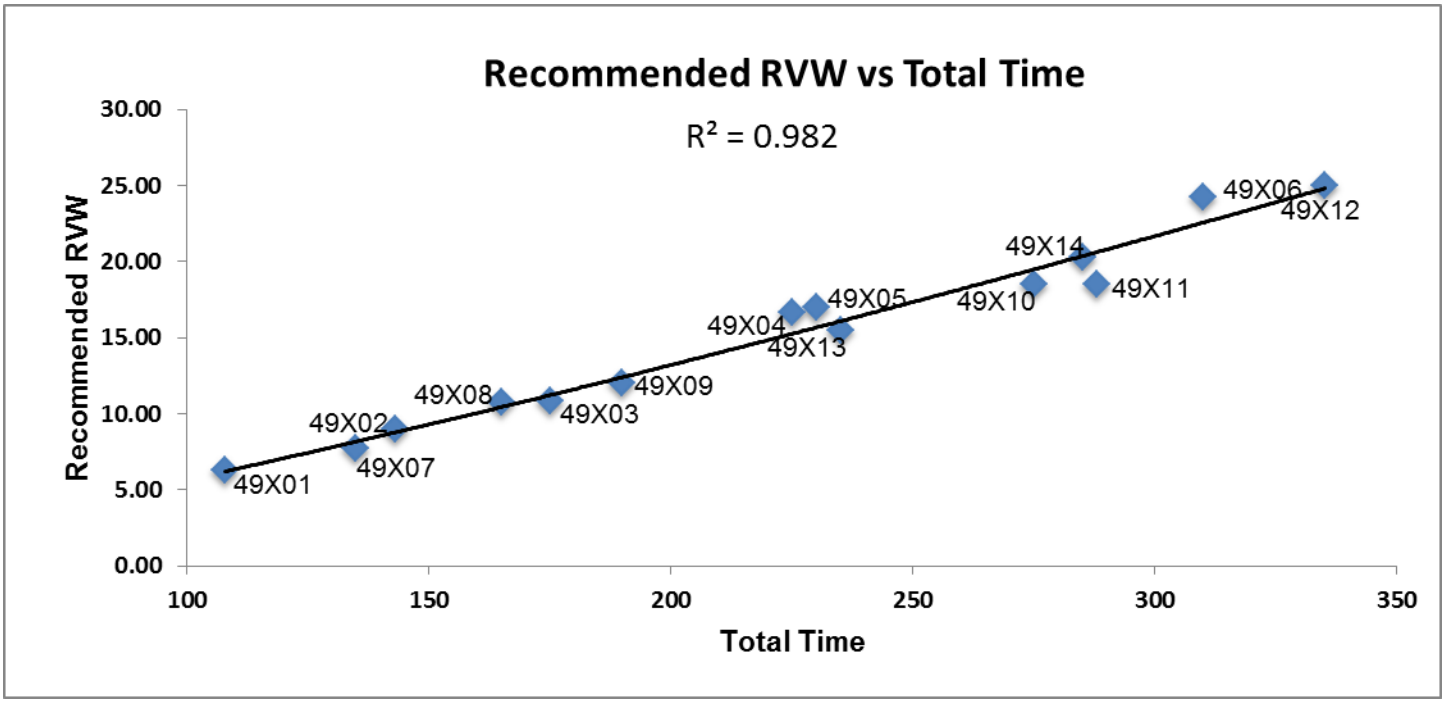
The codes in the table below that include extensive, complex and intense 0-day global procedures, bracket the recommendation for the survey code and offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	**20.00**	0.192	0.097	207	55	92	60	
49622	Parastomal, I/S	**20.25**	0.113	0.071	285	70	150	25	99232
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	**21.70**	0.148	0.097	223	58	135	30	

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.



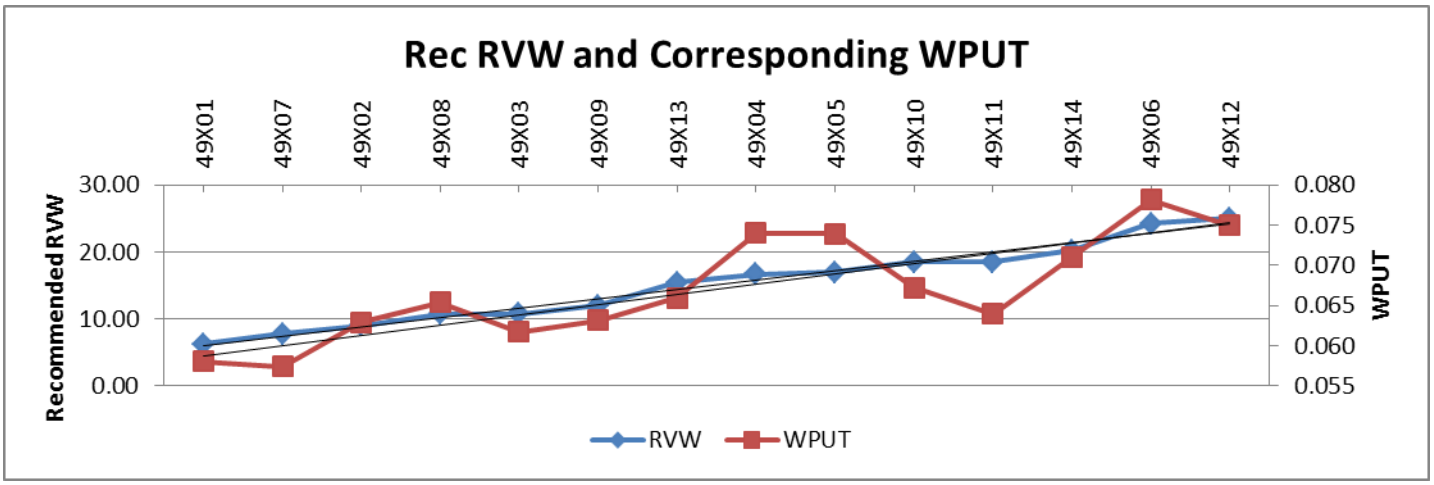
The data below that were used to create the chart above show appropriate relative rank order for work for this new set of hernia repair codes.

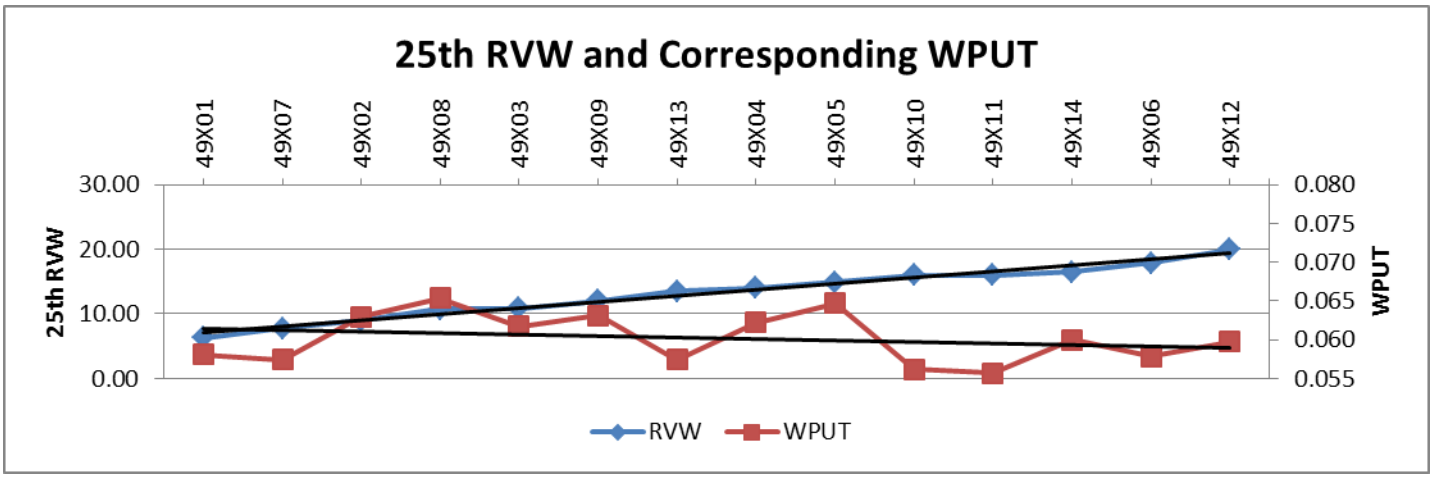
CPT	DESC		REC RVW	Total Time
49591	**Initial,** Reduc, < 3cm	25th	**6.27**	**108**
49613	**Recurrent,** Reduc, < 3cm	25th	**7.75**	**135**
49592	**Initial, I/S,** < 3cm	25th	**9.00**	**143**
49614	**Recurrent, I/S,** < 3cm	25th	**10.79**	**165**
49593	**Initial,** Reduc, 3-10cm	25th	**10.80**	**175**
49615	**Recurrent,** Reduc, 3-10cm	25th	**12.00**	**190**
49621	Parastomal, Reduc	median	**15.50**	**235**

49594	**Initial, I/S,** 3-10cm	median	**16.65**	**225**
49595	**Initial,** Reduc, > 10cm	median	**17.00**	**230**
49616	**Recurrent, I/S,** 3-10cm	median	**18.50**	**275**
49617	**Recurrent,** Reduc, > 10cm	median	**18.53**	**288**
49622	Parastomal, **I/S**	75th	**20.25**	**285**
49596	**Initial, I/S,** > 10cm	75th	**24.24**	**310**
49618	**Recurrent, I/S, > 10cm**	75th	**25.00**	**335**

Comparison of using the recommended RVW versus using the 25th percentile.

The first chart below shows reasonable correlation between the recommended RVW and WPUT—both trend lines have a similar slope. The second chart below shows no relationship of WPUT to the 25th percentile RVW—where WPUT decreases as work increases.





What if surgeon evaluation and management work were set equal to discrete E/M services?

As has been discussed by the RUC in the past, work intensities used for computation of IWPUT for time spent by physicians in the pre-service and immediate post-service period for surgical procedures have remained fixed since the early 1990s, while intensity of time for E/M values has received several increased values over several decades.

Recent increases for outpatient office E/M values were not allowed to be added to global codes by CMS. Because IWPUT is calculated by subtracting the pre- and post-work values from the RVW of a given CPT code, this has resulted in less value subtracted than would have occurred if the more appropriate pre- and post-work values were used for the IWPUT formula. This artificially increases the IWPUT and WPUT resulting in a decrease in relativity. This is especially true for codes that have a significant amount of pre-service and post-service work.

It has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of discounting of pre-service and post-service work. For example, for the top 34 high volume 10 and 90 day global codes, AMA staff recently calculated the difference in IWPUT if the office visit increases were used in the IWPUT equation. The AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT would have decreased from -6% to -548% depending on the number of office visits included in the work/time file. To emphasize the importance of this information, the code which would have had the largest decrease (17000) has 3 minutes of intra-time and only one postop office visit (99212). In this table, it was also clear that relativity within a family of codes is lost, because each code within a family may have varying levels of post-service work. To summarize, IWPUT has become much less accurate when used as a comparator of intra-service work within and between families because of CMS actions (ie, not updating global RVW) and policy (ie, discounting postoperative work).

Using the discussion above, we have created the table below that presents the IWPUT and WPUT for the hernia set of codes using (1) the 2021 formulas, and (2) "full value" formulas. The note below the table describes each formula, but basically the full value formula sets pre- and post-service work equal to the same E/M work for non-surgical services. For comparison to facility non-surgical services, we have included codes 99283-99285 using the 2021 published RVW and time data. This table shows that most of the recommendations for 49591-49622 result in a WPUT that is less than an ED visit requiring moderate MDM (99284). This table also shows that those codes with similar WPUT to high MDM are appropriately the bigger and more complex procedures. Last, this table provides evidence that discounting pre- and post-work distorts and artificially impacts fair IWPUT and WPUT relativity comparison. However, if undiscounted work is applied, the recommendations for this set of codes are appropriately ranked.

CPT	DESC	REC RVW	2021 formula*		2021 full value**		Total Time	PRE	Intra	Imm Post	-33 -26	-32 -25	-31 -24	Facility Status
			IWPUT	WPUT	IWPUT	WPUT								
99283	Low MDM	**1.60**	0.084	**0.053**	0.089	**0.053**	**30**	5	**15**	10				
49591	Initial, Reduc, < 3cm	**6.27**	0.113	**0.058**	0.079	**0.058**	**108**	43	**45**	20				same day
49613	Recurrent, Reduc, < 3cm	**7.75**	0.105	**0.057**	0.075	**0.057**	**135**	55	**60**	20				same day
49592	Initial, I/S, < 3cm	**9.00**	0.123	**0.063**	0.085	**0.059**	**153**	53	**60**	20			1	overnight
49614	Recurrent, I/S, < 3cm	**10.79**	0.120	**0.065**	0.088	**0.062**	**175**	60	**75**	20			1	overnight
49593	Initial, Reduc, 3-10cm	**10.80**	0.101	**0.062**	0.076	**0.058**	**185**	55	**90**	20			1	overnight
49615	Recurrent, Reduc, 3-10cm	**12.00**	0.102	**0.063**	0.078	**0.060**	**200**	60	**100**	20			1	overnight
49621	Parastomal, Reduc	**15.50**	0.107	**0.066**	0.089	**0.066**	**235**	70	**120**	25			1	inpatient
49594	Initial, I/S, 3-10cm	**16.65**	0.121	**0.074**	0.097	**0.068**	**245**	65	**120**	20		1		overnight
49595	Initial, Reduc, > 10cm	**17.00**	0.123	**0.074**	0.098	**0.068**	**250**	70	**120**	20		1		overnight
49616	Recurrent, I/S, 3-10cm	**18.50**	0.109	**0.067**	0.093	**0.067**	**275**	70	**140**	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	**18.53**	0.101	**0.064**	0.086	**0.064**	**288**	70	**150**	28		1		inpatient
99284	Moderate MDM	**2.74**	0.106	**0.069**	0.098	**0.069**	**40**	6	**22**	12				
49622	Parastomal, I/S	**20.25**	0.113	**0.071**	0.099	**0.071**	**285**	70	**150**	25		1		inpatient
99285	High MDM	**4.00**	0.115	**0.073**	0.080	**0.073**	**55**	9	**30**	16				
49596	Initial, I/S, > 10cm	**24.24**	0.127	**0.078**	0.113	**0.078**	**310**	70	**160**	25	1			inpatient
49618	Recurrent, I/S, > 10cm	**25.00**	0.117	**0.075**	0.104	**0.075**	**335**	70	**180**	30	1			inpatient

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post intensity of 0.0224; scrub/dress/wait intensity of 0.0081; and discounted same-day outpatient postop visit (not shown in table) equal to intra-service time at 0.0224. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 (equal to WPUT for 99213) and same-day post EM at full value instead of discounted time for outpatient procedure as shown on table (highlighted in red).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49561 Repair initial incisional or ventral hernia; incarcerated or strangulated 090
49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated 090
49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49657 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy YYY
49999 Unlisted procedure, abdomen, peritoneum and omentum YYY
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,035
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 932 Percentage 90.04 %

Specialty Colorectal Surgery Frequency 52 Percentage 5.02 %

Specialty Other Surgery Frequency 52 Percentage 5.02 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the

Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49623 Tracking Number C16 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.00**

CPT Descriptor: Removal of mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: At the time of hernia repair, a 64-year-old obese male who had mesh placed with a prior hernia repair now requires removal of the mesh to allow for an adequate repair of a new hernia. Note: This is an add-on service. Only consider the additional work related to mesh removal.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Utilizing electrocautery and sharp dissection, the previously placed mesh is dissected from the abdominal wall fascia. Care is taken to prevent damage to the abdominal wall and intraabdominal contents while removing the mesh in its entirety. Prior sutures and tacks are identified and dissected from the abdominal wall. Hemostasis is obtained in the abdominal wall over the surface area of the excised mesh.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	49623					
Sample Size:	4200	**Resp N:**	150			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**3.00**	10.00	100.00	
Survey RVW:	1.55	5.00	**5.00**	6.50	15.02	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	15.00	30.00	**45.00**	50.00	100.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	49623	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11008	ZZZ	5.00	**RUC Time**

CPT Descriptor Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
35572	ZZZ	6.81	**RUC Time**

CPT Descriptor Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 83 **% of respondents:** 55.3 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 8.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 49623	Top Key Reference CPT Code: 11008	2nd Key Reference CPT Code: **35572**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	60.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**60.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	67%	22%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	70%	23%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	65%	36%
Physical effort required	5%	61%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	64%	29%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	50%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	33%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	25%	67%
Physical effort required	8%	17%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	17%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day.

We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 49623 (add-on code)

We recommend a work RVU of 5.00, which is the survey median.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 49623 is similar to somewhat more than reference code 11008. Ref 2: The respondents indicated the intensity/complexity of survey code 49623 is somewhat more than reference code 35572.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	**4.13**	0.103	0.103	40	0	40	0
49623	**Removal of mesh**	**5.00**	**0.111**	**0.111**	**45**	**0**	**45**	**0**

Other Code Comparison

Codes 57267 and 63295, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	**4.88**	0.108	0.108	45	0	45	0
49623	**Removal of mesh**	**5.00**	**0.111**	**0.111**	**45**	**0**	**45**	**0**
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	**5.25**	0.112	0.095	55	10	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

49565-22 Repair recurrent incisional or ventral hernia; reducible 090
49566-22 Repair recurrent incisional or ventral hernia; incarcerated or strangulated 090
49656-22 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible 090
49657-22 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated 090
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy YYY
49999 Unlisted procedure, abdomen, peritoneum and omentum YYY

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Sometimes

Specialty colorectal surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,931
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 2638 Percentage 90.00 %

Specialty Colorectal Surgery Frequency 147 Percentage 5.01 %

Specialty Other Surgery Frequency 147 Percentage 5.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:15778 Tracking Number C1 Original Specialty Recommended RVU: **8.50**
Presented Recommended RVU: **8.50**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **8.00**

CPT Descriptor: Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male with a large abdominal wall defect as a result of necrotizing infection and extensive debridement of all involved skin, subcutaneous tissue, fascia, and muscle now undergoes delayed closure with implantation of absorbable mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Description of Pre-Service Work: Interval tests (imaging, electrocardiogram and labs) are reviewed. Appropriate selection, timing, and administration of DVT prophylaxis are ensured. Appropriate selection, timing, and administration of antibiotics are ensured. The need for beta-blockers is assessed, and they are ordered as required. The patient is reexamined to confirm that physical findings have not changed. The history and physical examination are then updated in the electronic health record. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is reviewed and obtained from the patient, including witness confirmation. The length and type of anesthesia, including adjuncts to postoperative analgesia management, are reviewed with the anesthesiologist. Verify that all required instruments and supplies are available, including mesh. Assistance is provided in transfer of the patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. The dressing covering the wound from the previous debridement is removed. The areas of skin to be prepared and draped are indicated by the surgeon to ensure that all of the potential operative field is included in the preparation. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team.

Description of Intra-Service Work: Extent of the open wound is examined including assessment of adherence of intestine and intra-abdominal contents to the fascia. Adhesiolysis is performed separating these contents from the fascial boundaries to allow for mesh fixation. Care is taken during the lysis of adhesions to avoid injury to inflamed, exposed intra-abdominal contents including small intestine and colon. Omentum is draped across the exposed intestine. The abdominal wall defect resulting from the surgical debridement is measured. An absorbable mesh is sized to allow for closure of the abdominal wall defect and re-establishment of abdominal wall integrity. The mesh is sutured to the fascial edges circumferentially avoiding errant placement of sutures injuring the inflamed, exposed intra-abdominal contents.

Description of Post-Service Work:
Immediate postoperative care [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff, including need for patient-controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review postoperative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final

operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders and discuss ongoing care with nursing staff.
Later same day hospital inpatient care visit [operative day after discharge from recovery room]: Review interval nursing/other staff chart notes. Discuss ongoing care with nursing staff. Evaluate vital signs and intake/output. Monitor fluid and electrolyte status and renal function. Examine patient and assess status of newly placed mesh. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS					
Specialty Society(ies):	ACS, SAGES, ASCRS					
CPT Code:	15778					
Sample Size:	1200	**Resp N:**	36			
Description of Sample:	random from membership databases					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	3.00	20.00	
Survey RVW:	5.00	8.00	**8.50**	10.00	20.25	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	50.00	60.00	**90.00**	96.00	120.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**95.00**	99231x **0.00** 99232x **1.00** 99233x **1.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	15778	**Recommended Physician Work RVU: 8.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**25.00**	**33.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49013	000	8.35	**RUC Time**

CPT Descriptor Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15273	000	3.50	**RUC Time**

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52353	000	7.50	**RUC Time**	11,180

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36905	000	9.00	**RUC Time**	41,205

CPT Descriptor 2 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 33.3 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 15778	Top Key Reference CPT Code: 49013	2nd Key Reference CPT Code: **15273**
Median Pre-Service Time	58.00	50.00	60.00
Median Intra-Service Time	90.00	45.00	20.00
Median Immediate Post-service Time	25.00	60.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	40.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**213.00**	**155.00**	**100.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	17%	58%	8%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	17%	58%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	0%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	13%	88%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

RAW Screen

Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC/RAW with a site of service anomaly: less than 50% inpatient status; includes inpatient visit codes; greater than 5,000 utilization. Prior to

submitting an Action Plan to the RAW, the societies reviewed the site of service data and found: almost even split of 48% between inpatient and outpatient – with a few percent in the ASC. At the January 2020 RUC meeting, the societies requested referral of code 49565 to CPT to update the descriptor to current standard of practice and typical patient presentation.

CPT Coding Changes

At the February 2021 CPT meeting the following changes were approved:

- Delete all the current open and laparoscopic codes for repair of anterior abdominal hernias.
- Delete add-on code 49568 for mesh for open ventral/incisional hernias and large defects as a result of necrotizing soft tissue infection.
- Add 12 new codes for anterior abdominal hernia repair by any approach (ie, open laparoscopic, robotic); by initial or recurrent; by total defect size; and by reducible or incarcerated/strangulated
- Add 2 codes for parastomal hernia repair - by reducible or incarcerated/strangulated
- Add 1 add-on code for removal of mesh/prosthesis – only with the new hernia repair codes
- Add 1 new code for mesh/prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma.

Coding Structure

Hernia repair for epigastric, incisional, ventral, umbilical, spigelian were merged as they all appear on the anterior abdomen. The location--upper, lower, midline—does not impact the work. But instead, the size and number of defects is the driving factor for work. For example, with respect to the code that was tagged by the RAW, a recurrent, incisional, reducible hernia can be anywhere from a small hernia at a port site from a prior laparoscopic procedure to an extremely large hernia with multiple defects clustered in a midline incision.

Initial versus recurrent differentiation was maintained. Recurrent hernias are re-reoperations. An initial hernia can be the result of a prior procedure (this is not a recurrent hernia) or weak muscles and fascia. A recurrent hernia is typically at least the third time the same site is being operated on.
For example,

- operation 1 might be an open colectomy
- operation 2 would be an initial midline hernia repair
- operation 3 would be a recurrent midline hernia involving the initial midline repair and may include other multiple hernias occurring in the same old incision, all needing to be repaired.

There are many examples in CPT that differentiate between a primary and secondary procedure: disarticulation of shoulder (23920-23921); amputation of arm through humerus (24900-24930) and other similar amputation families; tendon repair (eg, 25260-25274); CABG reoperation (33530); and revision total joint (eg, 23473, 23474, 24370, 24371, 27134-27138).

The hernia size ranges were based on a review of literature and expert panel. For example, an article published in the Journal of the American College of Surgeons reviewed technique and outcomes of abdominal incisional hernia repair and showed that the range of defect size was from less than 1 cm to more than 25 cm with a mean of 6 cm and a median of less than 3 cm. Other similar articles were submitted with the code change application, supporting different work for different defect size. David A. Iannitti, et.al, *Technique and Outcomes of Abdominal Incisional Hernia Repair Using a Synthetic Composite Mesh: A Report of 455 Cases,* Journal of the American College of Surgeons, Volume 206, Issue 1, 2008, Pages 83-88, ISSN 1072-7515, https://doi.org/10.1016/j.jamcollsurg.2007.07.030.

Differentiating the work of a procedure in relationship to size or extent is not new for CPT. For example, 36 skin repair codes by length of repair; 44 lesion excision codes by excised diameter; 46 soft tissue tumor excision codes by size of tumor; 23 hysterectomy codes by size of uterus (58260-58573); 3 myomectomy codes are differentiated by total weight of the myomas (58140-58146); and 10 nerve graft codes are based on length of graft. (64885-64898)

The CPT guidelines and illustrations that describe how to measure the total defect size are well understood by surgeons. This is not a new concept – surgeons are very familiar with measuring a hernia defect, and in fact the size of the hernia defect was included in some of the patient vignettes in 1993. Furthermore, measurement of hernia size is a necessary step for selecting and preparing the appropriately sized mesh for implantation.

Hernia repair coding has been complicated by changes in (1) technology and technique and (2) the recent implementation of ICD-10-PCS codes. For these reasons, the stakeholder societies believed this set of codes should

describe "any approach." The societies and the AMA Coding Network have received numerous coding questions about correct reporting for "hybrid" abdominal hernia repair procedures where parts of the procedure are performed via an open approach and parts of the procedure are performed via laparoscopy or with the use of a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that are more often begun open and then finished as laparoscopic/robotic under pneumoperitoneum.

Another issue that has recently caused confusion about coding has appeared on national coder websites and coder discussion boards referring to International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes which classifies procedures performed in the facility (ie, not CPT physician procedures). This, however, is important because facilities want the procedure codes reported to correspond with the descriptors of ICD-10-PCS codes that the facility is reporting. Unfortunately, the new ICD-10-PCS codes define various surgical approaches that do not correspond to CPT coding (open, closed, percutaneous, and laparoscopic). For example, the ICD-10-PCS "open endoscopic" approach is defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose a body part, and introduction of instrumentation to reach and visualize the site of the procedure." A second example is the "open with percutaneous endoscopic assistance" approach defined as "cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure." These new ICD-10-PCS codes have resulted in coders stating that a procedure should be reported as open because the ICD-10-PCS code indicates open and to report any procedure that includes extension of a port incision (eg, for delivery of a specimen) to be reported as an open procedure --instead of being correctly reported as a laparoscopic procedure.

Mesh

- **Implantation of mesh is now typical and therefore was bundled into the new codes.** When code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the CCA.

- **Mesh removal is not always required and is not typical.** Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed, which our expert panel believes is not typical of most hernia repairs.

- **Deletion of code 49658 resulted in rare "left over" work for implantation of mesh related to closure for a large open wound after debridement for necrotizing fasciitis.** Add-on code 46958 was reported for mesh placement for both open hernia repair and in relation to closure of wounds from necrotizing soft tissue infection. This code will be deleted and the work of mesh placement will be included in the work for all of the anterior abdominal hernia repair codes. The remaining use of code 46958 was for mesh placement for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma. As described in the vignette for 15778, necrotizing soft tissue infections typically result in a large open wound that cannot be closed primarily. When the infection has resolved, absorbable mesh or other prosthesis is placed to allow healing by secondary intent until such time that a skin graft or skin closure can be accomplished. The literature submitted with the CCA supports this work.

Compelling Evidence - Flawed methodology of previous reviews, New technology

Flawed Methodology: Codes 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, and 49590 were last reviewed in 2000 during the 2nd 5-year-review. During this review, the American College of Surgeons argued that there was compression of work values for big procedures and there were rank order issues within families of codes. We developed a methodology using NSQIP data that was approved by the Research Subcommittee. However, to validate the methodology, the 5YR Workgroup instructed the ACS to group the codes into families and survey one or two CPT codes as full surveys per family to act as anchors for each family and the rest of the codes to be surveyed as mini-

surveys for only time and visits. After conducting all of the surveys, we believe we were able to validate the methodology that we proposed, however, the 5YR Workgroup did not agree. Instead, they decided that the value that they assigned to the anchor code (the full survey) would be extrapolated to all of the other codes grouped into the same survey. The hernia codes listed above were grouped with 49505 which was increased by 17% based on the survey data and compelling evidence. The 17% increase was applied to the other codes in the group without consideration of rank order, mini survey results or society recommendations. This resulted in continuation of compression and rank order issues. For example, although code 49572 was increased by 17%, the IWPUT for the code is negative. Other codes have near zero IWPUT. **We believe this was a flawed methodology of review of the codes and meets compelling evidence.**

Flawed Methodology: Codes 49587, 49652, 49653, 49654, and 49655 were last reviewed in 2011 based on a site of service anomaly screen. At that time, the RUC approved including a same day observation visit and full observation discharge on the subsequent day. The RUC noted that the typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status (in patient moving to outpatient—as determined by CMS) has little to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which showed that the typical patients stayed at least overnight and received a postoperative same-day E/M service. Given this data, the RUC enacted its (then current) policy to allocate the appropriate proxy for the postoperative visits which was categorized as either subsequent observation and/or observation discharge—both of which are outpatient codes. Importantly, the specialties argued and the RUC agreed that the work of providers who care for medical patients should not be discounted (eg, full observation E/M and full observation discharge E/M allowed for patient staying overnight for observation.)

CMS ignored the valid outpatient E/M visit code inputs that the RUC recommended and instead stated in the Rule that they have a policy of not allowing "inpatient" visits included in the details for outpatient services. These codes went through a Refinement Panel process [ie, a CMS convened group of Medical Officers and select physicians acting as a separate formal appeals process] that resulted in agreement with the RUC recommendations. Importantly, the Agency still maintained that inpatient visits would not be allowed (even though outpatient/observation visits were submitted by the RUC) and then used a reverse building block methodology to subtract work RVUs from the values. These values had been developed by magnitude estimation and approved by the RUC. The Agency deleted the observation visit code inputs and decreased discharge management by 50 percent even though it was performed on a subsequent date. **We believe this action by CMS resulted in a flawed methodology of review of these codes and meets compelling evidence.**

The rejection of equal value for equal work and rejection of the Refinement Panel results prompted the Executive Director of the American College of Surgeons to send a letter (see last page of SoR) to Kathleen Sebelius, then Secretary of the Department of Health and Human Services on November 29, 2011. This letter addressed the decision-making process for valuing procedure codes that have Medicare outpatient status, the use of refinement panels, and the arbitrary discount in physician work for the same work performed by any provider of a non-global service. Specifically, the letter included the following statement:

> *"CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. …we believe that this policy leads to a loss of validity and integrity of the current system."*

We continue to believe there is no valid justification for a 50% discount to discharge management services provided by a surgeon that is performed the day after a procedure when a non-surgical provider observing a medical patient who is kept overnight for any reason is allowed to bill a discharge management service at 100 percent for work on the next day. We also believe there is no valid justification for discounting a postoperative visit later the same day of surgery to equal only the intra-service time of the visit multiplied by an intensity of 0.0224. No surgeon would round on a postoperative patient the same day and not review interval chart notes prior to the face-to-face with the patient and not followup with charting the visit and confirming or modifying the current orders.

CMS implemented a 23-hour policy for discounting surgical postoperative work based on the argument that the Agency could not include impatient work in their time/work file. However, the fact is that the Agency has also erroneously

rejected RUC recommendations for outpatient / observation codes, stating "these inpatient codes" could not be included for procedure that are typically outpatient.

Change in Technology: Since the last review of the hernia repair codes (either in 2000 or in 2011), there has been introduction and application of new technology (ie, robotic assist) which adds work complexity and time with the goal of better patient outcomes. The diffusion of this new technology throughout this family of codes further meets compelling evidence.

Recommendation – 15778

We recommend a work RVU of 8.50, which is the survey median.

Pre-service time

Scrub, dress, wait package time has been reduced so as to not exceed survey median data.

Postoperative E/M visit later on the day of surgery

The typical patient will be inpatient and a visit will occur later on the same day. Review data (eg, diagnostic and imaging studies) not available at the unit. Communicate with other health care professionals and with patient and/or family. Review medical records and data available on the unit. Perform a medically appropriate examination. Consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM). Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals as necessary. Write and/or review orders, including arranging for necessary diagnostic testing, consultation(s), and therapeutic intervention(s). Complete medical record documentation. Address interval data obtained and reported changes in condition. Communicate results and additional care plans to other health care professionals and to the patient and/or family.

Key Reference Code Intensity/Complexity Comparison

Ref 1: The respondents indicated the intensity/complexity of survey code 15778 is somewhat more than reference code 49013. Ref 2: The respondents indicated the intensity/complexity of survey code 15778 is somewhat/much more than reference code 15273.

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST	SD E/M
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	**7.50**	0.101	0.056	133	53	**60**	20	
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma	**8.50**	**0.061**	**0.040**	**213**	**58**	**90**	**25**	**99232**
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	**9.00**	0.106	0.071	126	31	**75**	20	

Other Code Comparison

The table below presents codes reviewed by the RUC since 2005 with 90 minutes intra-service time. Unlike 15778, almost all of the codes on this list with an RVW less than 12 are typically performed in the outpatient setting and some are performed a significant amount of time in an office setting.

Year	CPT	Long Descriptor	RVW	IWPUT	WPUT	Total	PRE	INTRA	POST	91	33	32
2007	**55920**	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	**8.31**	0.074	0.047	**175**	55	**90**	30			

2005	**37184**	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	**8.41**	0.080	0.056	**150**	30	**90**	30			
	15778	Implantation of absorbable mesh or other prosthesis for delayed closure of external genitalia, perineum and/or abdominal wall defect(s) due to soft tissue infection or trauma	**8.50**	0.061	0.040	**213**	58	**90**	25			1
2013	**37241**	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	**8.75**	0.085	0.062	**142**	22	**90**	30			
2013	**37236**	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	**8.75**	0.083	0.058	**151**	31	**90**	30			
2015	**77778**	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	**8.78**	0.085	0.061	**145**	25	**90**	30			
2007	**41019**	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	**8.84**	0.079	0.051	**175**	55	**90**	30			
2011	**52355**	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	**9.00**	0.084	0.055	**163**	53	**90**	20			
2017	**32994**	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	**9.03**	0.082	0.054	**168**	48	**90**	30			
2010	**37221**	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	**9.75**	0.092	0.062	**158**	38	**90**	30			
2010	**37226**	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	**10.24**	0.098	0.065	**158**	38	**90**	30			

2016 **MPC**	**36906**	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	**10.42**	0.104	0.074	**141**	31	**90**	20			
2010	**37228**	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	**10.75**	0.103	0.068	**158**	38	**90**	30			
2016	**61640**	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	**12.32**	0.095	0.053	**233**	58	**90**	30		1	
2013 **MPC**	**37244**	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	**13.75**	0.135	0.083	**166**	31	**90**	45			
2013	**93583**	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	**13.75**	0.133	0.077	**178**	48	**90**	40			
2016	**33340**	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	**14.00**	0.136	0.077	**183**	63	**90**	30			
2014	**33988**	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	**15.00**	0.097	0.060	**250**	60	**90**	30	1		
2014	**33955**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	**16.00**	0.108	0.064	**250**	60	**90**	30	1		
2014	**33956**	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	**16.00**	0.108	0.064	**250**	60	**90**	30	1		

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
49999 Unlisted procedure, abdomen, peritoneum and omentum YYY
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) ZZZ

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty colorectal surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 291
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details

Specialty General Surgery Frequency 262 Percentage 90.03 %

Specialty Colorectal Surgery Frequency 15 Percentage 5.15 %

Specialty Other Surgery Frequency 15 Percentage 5.15 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 11008

Letter Referenced in Compelling Evidence Rationale

November 29, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CY 2012 Medicare Physician Fee Schedule Final Rule and CMS
Refinement Panels

Dear Secretary Sebelius:

On November 28, 2011, the Federal Register published the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2012 Medicare Physician Fee Schedule Final Rule. On behalf of the American College of Surgeons (ACS), I am writing to express concern regarding the decision making process and lack of transparency on the part of CMS related to the work relative value units (wRVUs) for 2012 reviewed under CMS' refinement panel process. The ACS, with over 78,000 members, is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient.

The ACS has participated in the efforts of the American Medical Association's Relative Value Scale Update Committee (AMA RUC) for years given the value we place on the AMA RUC process and our assumption that CMS will evaluate the RUC recommendations with fairness, transparency, and accuracy according to a process that has been set out via the Federal rulemaking process. As part of the work that led to the CY 2012 Medicare Physician Fee Schedule Final Rule, the ACS devoted significant resources to conducting AMA RUC surveys for over 100 new or existing codes at the request of CMS. The AMA RUC evaluated wRVU recommendations made by the ACS, based upon those surveys, and came to agreement on final recommended values to be submitted to CMS.

Fifty-seven of the aforementioned codes that the ACS surveyed were sent to the refinement panel. CMS accepted ***only 12 percent*** of those refinement panel recommendations.

For most of the 88 percent of refinement panel recommendations that CMS rejected, CMS lowered the wRVU by reducing the value of the post-operative evaluation and management work performed by surgeons in the hospital by 69 percent. However, if that same work is performed by any other physician other than the surgeon, that same service is paid at 100 percent. We believe that the refinement panel physicians completely rejected this concept as they agreed to a work RVU that did not discount post-surgical work in this fashion. We note that the multispecialty panel included

physicians from primary care, contractor medical directors (CMDs), physicians in related specialties, and general surgeons. At no time did the Agency's Medical Officer in charge of the panel process disagree with the presenters or offer a contrary opinion to the discussion.

Our concerns were piqued when CMS issued the CY 2011 Medicare Physician Fee Schedule Final Rule in which CMS stated that it could change wRVU recommendations of the refinement panel convened by CMS if "policy concerns warrant their modification," without providing additional clarification on what would trigger this ability of CMS to subvert the more transparent process of the refinement panel. However, we continued to participate in the process under the belief that CMS would operate fairly and transparently and that if there were indeed "policy concerns" that CMS had regarding the values of the codes under consideration that those concerns would be stated clearly so all parties could address them during the refinement panel reviews.

CMS has now implemented a policy by which it is creating differential payments for the same work performed by different physicians as a backdoor mechanism for reducing the work RVUs for surgical procedures. They have valued the worth of a surgeon for post-operative evaluation and management work at about 30 percent of a non-surgeon.. Non-surgeons are allowed to provide the same work to the same patient at 100 percent reimbursement. First, we believe that this policy leads to a loss of validity and integrity of the current system. In addition, this policy is prohibited by the Omnibus Budget Reconciliation Act of 1989, which states, "[t]he Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." (42 U.S.C. §1395w-4(c)(6)).

The ACS has been a vocal proponent of needed reforms in the delivery and payment of health care. We believe that the future of these reforms will be based on driving greater awareness of proven continuous quality improvement programs to achieve ongoing, tangible results for quality improvements. However, in order for these reforms to be effective, they must be built on a system that is consistent with previous Agency decisions, fair, and transparent, and it is our concern that many of the policy decisions made by CMS in the latest Medicare Physician Fee Schedule Final Rule move us away from those goals. The resource based relative value system (RBRVS) requires a resource basis for decisions on the valuation of physician services. We believe that the resource basis for the decision to reduce these values is not evident. We ask that under your authority as Secretary you will seek to have CMS define a more transparent process in the future for decisions that are not aligned with the RUC and refinement panel recommendations in order to help maintain the transparency and fairness of the current system and to restore the values of these services to the level that is supported by the RBRVS process.

Sincerely,
David B. Hoyt, MD, FACS
Executive Director

ISSUE: Anterior Abdominal Hernia Repair
TAB: 9

NEW CODES	size	init or recur	reduc or I/S	Current codes:	49560	49654	49565	49656	49570	49585	49652	49590	49561	49655	49566	49657	49572	49587	49653	49659	49999	+49568
					Repair initial incisional or ventral hernia; reducible	Laparoscopy, surgical, repair, initial incisional hernia .... reducible	Repair recurrent incisional or ventral hernia; reducible	Laparoscopy, surgical, repair, recurrent incisional hernia	Repair epigastric hernia (eg, preperitoneal fat); reducible	Repair umbilical hernia, age 5 years or older; reducible	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or	Repair spigelian hernia	Repair initial incisional or ventral hernia; incarcerated or	Laparoscopy, surgical, repair, initial incisional hernia ...incarcerate	Repair recurrent incisional or ventral hernia; incarcerated	Laparoscopy, surgical, repair, recurrent incisional hernia ...;	Repair epigastric hernia (eg, preperitoneal fat); incarcerated	Repair umbilical hernia, age 5 years or older; incarcerated	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy,	Unlisted procedure, abdomen, peritoneum and omentum	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh
				2019E UTIL ➢	22,089	7,253	5,211	1,697	616	18,847	9,327	714	12,726	4,804	3,748	1,503	451	7,947	5,848	980	1,327	27,767
				Est UTIL ➘																		
49591	<3cm	Initial	Reduc	43,628	65%	40%			99%	95%	80%	55%										99%
49593	3-10cm	Initial	Reduc	12,662	30%	50%			1%	4%	15%	35%										
49595	>10cm	Initial	Reduc	2,191	4%	9%				1%	5%	0%										
49592	<3cm	Initial	I/S	23,602								5%	65%	65%			99%	85%	85%			
49594	3-10cm	Initial	I/S	7,231								5%	30%	30%			1%	14%	14%			
49596	>10cm	Initial	I/S	839									4%	4%				1%	1%			
49613	<3cm	Recur	Reduc	1,642			25%	20%														
49615	3-10cm	Recur	Reduc	4,575			65%	70%														
49617	>10cm	Recur	Reduc	622			9%	9%														
49614	<3cm	Recur	I/S	1,050											20%	20%						
49616	3-10cm	Recur	I/S	3,676											70%	70%						
49618	>10cm	Recur	I/S	473											9%	9%						
49621	init or recur		Reduc	709	1%	1%	1%	1%												15%	15%	
49622	init or recur		I/S	1,035									1%	1%	1%	1%				35%	35%	
49623	Removal of mesh or other			2,931			25%	5%							35%	8%				10%	1%	
15778	Implantation of absorbable			291																	1%	1%

CPT Code	Est. Utilization	Specialty	Specialty Utilization
49591	43,628	General Surgery	39,265
	43,628	Colorectal Surgery	2,181
	43,628	Other Surgery	2,181
49592	23,602	General Surgery	21,242
	23,602	Colorectal Surgery	1,180
	23,602	Other Surgery	1,180
49593	12,662	General Surgery	11,396
	12,662	Colorectal Surgery	633
	12,662	Other Surgery	633
49594	7,231	General Surgery	6,507
	7,231	Colorectal Surgery	362
	7,231	Other Surgery	362
49595	2,191	General Surgery	1,972
	2,191	Colorectal Surgery	110
	2,191	Other Surgery	110
59596	839	General Surgery	755
	839	Colorectal Surgery	42
	839	Other Surgery	42
49613	1,642	General Surgery	1,478
	1,642	Colorectal Surgery	82
	1,642	Other Surgery	82
49614	1,050	General Surgery	945
	1,050	Colorectal Surgery	53
	1,050	Other Surgery	53
49615	4,575	General Surgery	4,118
	4,575	Colorectal Surgery	229
	4,575	Other Surgery	229
49616	3,676	General Surgery	3,308
	3,676	Colorectal Surgery	184
	3,676	Other Surgery	184
49617	622	General Surgery	560
	622	Colorectal Surgery	31
	622	Other Surgery	31
49618	473	General Surgery	425
	473	Colorectal Surgery	24
	473	Other Surgery	24
49621	709	General Surgery	638
	709	Colorectal Surgery	35
	709	Other Surgery	35
49622	1,035	General Surgery	932
	1,035	Colorectal Surgery	52
	1,035	Other Surgery	52
49623	2,931	General Surgery	2,638
	2,931	Colorectal Surgery	147
	2,931	Other Surgery	147
15778	291	General Surgery	262
	291	Colorectal Surgery	15
	291	Other Surgery	15

ISSUE: Anterior Abdominal Hernia Repair
TAB: 9

SOURCE	Review Year	CPT	DESC	Glob	Resp	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD P-SD	POST Facility 91	POST Facility 33	POST Facility 32	POST Facility 31	POST Facility 38	POST Facility 39	POST-Office 15	POST-Office 14	POST-Office 13	POST-Office 12	POST-Office 11	12 Month Svy Experience MIN	12 Month Svy Experience 25th	12 Month Svy Experience MED	12 Month Svy Experience 75th	12 Month Svy Experience MAX
REF1	2016	31600	Tracheostomy, planned (separate procedure);	0	6	0.123	0.046			5.56			120	40	10	10			30			30																
REF2	2015	43210	Esophagogastroduodenoscopy, flexible, transoral; with esc	0	6	0.100	0.052			7.75			148	33	10	15			60			30																
Current	2000	49560	Repair initial incisional or ventral hernia; reducible	090		0.091	0.053			11.92			223	45					90			30				0.5			1	1						
Current	2000	49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (	090		0.038	0.031			6.05			193	45					60			30				0.5			1	1						
Current	2000	49585	Repair umbilical hernia, age 5 years or older; reducible	090		0.063	0.037			6.59			178	45					45			30				0.5			1	1						
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046			8.90			193	45					60			30				0.5			1	1						
Current	2011	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.084	0.046			11.92			258	40	15	15			90			40				0.5			1	1						
Current	2011	49654	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.077	0.046			13.76			298	40	15	15			120			50				0.5			1	1						
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52																	
SVY	2021	49591	Initial, Reducible, < 3cm	0	39	0.148	0.070	4.95	6.27	8.00	10.00	16.00	115	25	10	15	20	40	45	60	90	20												3	10	20	40	76
REC		49591	25th percentile RVW	0		0.113	0.058			6.27			108	25	3	15			45			20															
																						Same day discharge															
REF1	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	6	0.087	0.054			14.24			265	30	15	15			120			30		1														
REF2	2014	33956	Extracorporeal membrane oxygenation (ECMO)/extracorp	0	6	0.108	0.064			16.00			250	30	15	15			90			30	1														
Current	2000	49561	Repair initial incisional or ventral hernia; incarcerated or str	090		0.074	0.044			15.38			352	45					100			30			2	1	1.0			1	1						
Current	2000	49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerate	090		-0.001	0.025			7.87			312	45					60			30			2	1	1.0			1	1						
Current	2011	49587	Repair umbilical hernia, age 5 years or older; incarcerated	090		0.049	0.032			7.08			221	40	3	20			60			40				0.5			1	1						
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046			8.90			193	45					60			30				0.5			1	1						
Current	2011	49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.082	0.048			14.94			314	40	15	15			120			50				0.5			1	2						
Current	2011	49655	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.079	0.049			16.84			344	40	15	15			150			50				0.5			1	2						
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52																	
SVY	2021	49592	Initial, Incarcerated/Strangulated, < 3cm	0	39	0.161	0.075	5.60	9.00	12.00	15.48	20.00	160	35	10	15	30	50	60	75	140	20				1								0	5	10	20	100
REC		49592	25th percentile RVW	0		0.123	0.063			9.00			143	35	3	15			60			30				0											
																						Overnight with visit on same date															
REF1	2004	11006	Debridement of skin, subcutaneous tissue, muscle and fas	0	8	0.077	0.049			13.10			270	30	15	20			120			30		1														
REF2	2004	11004	Debridement of skin, subcutaneous tissue, muscle and fas	0	5	0.077	0.045			10.80			240	30	15	20			90			30		1														
Current	2000	49560	Repair initial incisional or ventral hernia; reducible	090		0.091	0.053			11.92			223	45					90			30					0.5			1	1						
Current	2000	49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (	090		0.038	0.031			6.05			193	45					60			30					0.5			1	1						
Current	2000	49585	Repair umbilical hernia, age 5 years or older; reducible	090		0.063	0.037			6.59			178	45					45			30					0.5			1	1						
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046			8.90			193	45					60			30					0.5			1	1						
Current	2011	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.084	0.046			11.92			258	40	15	15			90			40					0.5			1	1						
Current	2011	49654	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.077	0.046			13.76			298	40	15	15			120			50					0.5			1	1						
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52																	
SVY	2021	49593	Initial, Reducible, 3-10cm	0	41	0.120	0.070	8.00	10.80	13.00	15.00	18.32	185	30	10	15	40	60	90	120	240	20				1								1	8	20	30	100
REC		49593	25th percentile RVW	0		0.101	0.062			10.80			175	30	10	15			90			30				0											
																						Overnight with visit on same date															
REF1	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	11	0.087	0.054			14.24			265	30	15	15			120			30		1														
REF2	2005	33891	Bypass graft, with other than vein, transcervical retrophary	0	6	0.098	0.062			20.00			323	70	20	20			173			40															
Current	2000	49561	Repair initial incisional or ventral hernia; incarcerated or str	090		0.074	0.044			15.38			352	45					100			30			2	1	1.0			1	1						
Current	2000	49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerate	090		-0.001	0.025			7.87			312	45					60			30			2	1	1.0			1	1						
Current	2011	49587	Repair umbilical hernia, age 5 years or older; incarcerated	090		0.049	0.032			7.08			221	40	3	20			60			40					0.5			1	1						
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046			8.90			193	45					60			30					0.5			1	1						
Current	2011	49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.082	0.048			14.94			314	40	15	15			120			50					0.5			1	2						
Current	2011	49655	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.079	0.049			16.84			344	40	15	15			150			50					0.5			1	2						
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52																	
SVY	2021	49594	Initial, Incarcerated/Strangulated, 3-10cm	0	41	0.113	0.068	10.90	14.00	16.65	20.00	24.00	245	35	15	15	60	90	120	150	300	20				1								0	3	8	20	100
REC		49594	25th percentile RVW	0		0.099	0.062			14.00			225	35	15	15			120			40				0											
																						Overnight with visit on same date															
REF1	2014	21813	Open treatment of rib fracture(s) with internal fixation, inclu	0	10	0.074	0.057			17.61			310	40	15	15			210			30															
REF2	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	5	0.087	0.054			14.24			265	30	15	15			120			30		1														
Current	2000	49560	Repair initial incisional or ventral hernia; reducible	090		0.091	0.053			11.92			223	45					90			30					0.5			1	1						
Current	2000	49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (	090		0.038	0.031			6.05			193	45					60			30					0.5			1	1						
Current	2000	49585	Repair umbilical hernia, age 5 years or older; reducible	090		0.063	0.037			6.59			178	45					45			30					0.5			1	1						
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046			8.90			193	45					60			30					0.5			1	1						
Current	2011	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.084	0.046			11.92			258	40	15	15			90			40					0.5			1	1						
Current	2011	49654	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.077	0.046			13.76			298	40	15	15			120			50					0.5			1	1						

Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49595	Initial, Reducible, > 10cm	0	40	0.115	0.068	10.00 14.88	17.00	19.00 35.00	250	40	15	15	60	90	120	151	240	20	1				1	5	10	20	50
REC		49595	25th percentile RVW	0		0.105	0.065		14.88		230	40	15	15			120			40	0							
																					Overnight with visit on same date						
REF1	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	10	0.087	0.054		14.24		265	30	15	15			120			30	1							
REF2	2002	61624	Transcatheter permanent occlusion or embolization (eg, fo	0	9	0.075	0.056		20.12		362	60	15	20			232			35								
Current	2000	49561	Repair initial incisional or ventral hernia; incarcerated or str	090		0.074	0.044		15.38		352	45					100			30	2	1	1.0	1	1			
Current	2000	49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerate	090		-0.001	0.025		7.87		312	45					60			30	2	1	1.0	1	1			
Current	2011	49587	Repair umbilical hernia, age 5 years or older; incarcerated	090		0.049	0.032		7.08		221	40	3	20			60			40			0.5	1	1			
Current	2000	49590	Repair spigelian hernia	090		0.086	0.046		8.90		193	45					60			30			0.5	1	1			
Current	2011	49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian c	090		0.082	0.048		14.94		314	40	15	15			120			50			0.5	1	2			
Current	2011	49655	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.079	0.049		16.84		344	40	15	15			150			50			0.5	1	2			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49596	Initial, Incarcerated/Strangulated, > 10cm	0	40	0.100	0.063	14.00 17.94	20.00	24.24 40.00	315	45	15	15	90	139	160	189	270	25	1				0	2	6	11	70
REC		49596	Median RVW	0		0.101	0.065		20.00		310	40	15	15			160			25	1							
																					Admitted						
REF1	2010	37225	Revascularization, endovascular, open or percutaneous, fe	0	7	0.087	0.063		11.75		186	30	3	5			118			30								
REF2	2018	49013	Preperitoneal pelvic packing for hemorrhage associated w	0	5	0.134	0.054		8.35		155	30	10	10			45			60								
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.067	0.042		15.08		362	45	15	15			120			30	1	1	1.0	1	1			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49613	Recurrent, Reducible, < 3cm	0	41	0.159	0.081	5.45 7.75	11.00	12.03 18.00	135	30	10	15	30	45	60	63	100	20					3	5	10	20	64
REC		49613	25th percentile RVW	0		0.105	0.057		7.75		135	30	10	15			60			20								
																					Same day discharge						
REF1	2014	21811	Open treatment of rib fracture(s) with internal fixation, inclu	0	6	0.073	0.049		10.79		220	40	15	15			120			30								
REF2	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	5	0.087	0.054		14.24		265	30	15	15			120			30	1							
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49657	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.072	0.045		22.11		493	60	15	15			180			30	2	1	1.0	1	2			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49614	Recurrent, Incarcerated/Strangulated, < 3cm	0	41	0.156	0.080	7.00 10.79	14.00	17.50 23.00	175	35	10	15	45	65	75	90	120	20	1				1	4	10	20	75
REC		49614	25th percentile RVW	0		0.120	0.065		10.79		165	35	10	15			75			30	0							
																					Overnight with visit on same date						
REF1	2004	11006	Debridement of skin, subcutaneous tissue, muscle and fas	0	7	0.077	0.049		13.10		270	30	15	20			120			30	1							
REF2	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	7	0.087	0.054		14.24		265	30	15	15			120			30	1							
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.067	0.042		15.08		362	45	15	15			120			30	1	1	1.0	1	1			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49615	Recurrent, Reducible, 3-10cm	0	43	0.127	0.075	8.50 12.00	15.00	17.75 22.00	200	35	10	15	60	83	100	123	270	20	1				0	5	10	21	78
REC		49615	25th percentile RVW	0		0.102	0.063		12.00		190	35	10	15			100			30	0							
																					Overnight with visit on same date						
REF1	2005	33891	Bypass graft, with other than vein, transcervical retrophary	0	11	0.098	0.062		20.00		323	70	20	20			173			40								
REF2	2014	21813	Open treatment of rib fracture(s) with internal fixation, inclu	0	9	0.074	0.057		17.61		310	40	15	15			210			30								
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49657	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.072	0.045		22.11		493	60	15	15			180			30	2	1	1.0	1	2			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49616	Recurrent, Incarcerated/Strangulated, 3-10cm	0	43	0.109	0.067	10.00 16.50	18.50	22.28 28.00	275	40	15	15	70	120	140	190	360	25	1				0	3	5	13	130
REC		49616	25th percentile RVW	0		0.094	0.060		16.50		275	40	15	15			140			25	1							
																					Admitted						
REF1	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	9	0.087	0.054		14.24		265	30	15	15			120			30	1							
REF2	2004	11006	Debridement of skin, subcutaneous tissue, muscle and fas	0	6	0.077	0.049		13.10		270	30	15	20			120			30	1							
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.067	0.042		15.08		362	45	15	15			120			30	1	1	1.0	1	1			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												
SVY	2021	49617	Recurrent, Reducible, > 10cm	0	42	0.101	0.064	11.50 16.03	18.53	22.00 40.00	288	40	15	15	70	120	150	178	300	28	1				0	2	7	12	45
REC		49617	XWALK - 37182	0		0.091	0.059		16.97		288	40	15	15			150			28	1							
XWALK	2002	37182	Insertion of transvenous intrahepatic portosystemic sh	0		0.104	0.081		16.97		210	30	0	0			150			30								
																					Admitted						
REF1	2002	61624	Transcatheter permanent occlusion or embolization (eg, fo	0	16	0.075	0.056		20.12		362	60	15	20			232			35								
REF2	2014	21813	Open treatment of rib fracture(s) with internal fixation, inclu	0	10	0.074	0.057		17.61		310	40	15	15			210			30								
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040		12.37		312	45					100			30	1	1	1.0	1	1			
Current	2007	49657	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.072	0.045		22.11		493	60	15	15			180			30	2	1	1.0	1	2			
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094		4.88		52				52												

SVY	2021	49618	Recurrent, Incarcerated/Strangulated, > 10cm	0	42	0.110	0.071	15.50	20.00	24.00	25.00	45.00	340	45	15	15	100	175	180	208	330	30	1				0	2	5	10	40
REC		49618	Median RVW	0		0.111	0.072			24.00			335	40	15	15			180			30	1								
																							Admitted							
REF1	2004	11005	Debridement of skin, subcutaneous tissue, muscle and fas	0	7	0.087	0.054			14.24			265	30	15	15			120			30	1								
REF2	2014	21813	Open treatment of rib fracture(s) with internal fixation, inclu	0	7	0.074	0.057			17.61			310	40	15	15			210			30									
Current	2000	49560	Repair initial incisional or ventral hernia; reducible	090		0.091	0.053			11.92			223	45					90			30			0.5	1 1					
Current	2000	49565	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040			12.37			312	45					100			30	1 1		1.0	1 1					
Current	2011	49654	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.077	0.046			13.76			298	40	15	15			120			50			0.5	1 1					
Current	2007	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.067	0.042			15.08			362	45	15	15			120			30	1 1		1.0	1 1					
Current	N/A	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhapl	YYY						N/A																					
Current	N/A	49999	Unlisted procedure, abdomen, peritoneum and omentum	YYY						N/A																					
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52												
SVY	2021	49621	Parastomal, Reducible	0	39	0.107	0.065	8.35	13.50	15.50	18.00	28.00	237	42	15	15	70	99	120	155	280	25	1				0	1	2	5	10
REC		49621	XWALK - 11005	0		0.096	0.061			14.24			235	40	15	15			120			25	1								
XWALK	2004	11005	Debridement of skin, subcutaneous tissue, muscle an	0		0.087	0.054			14.24			265	30	15	15			120			30	1								
																							Admitted							
REF1	2014	21813	Open treatment of rib fracture(s) with internal fixation, inclu	0	10	0.074	0.057			17.61			310	40	15	15			210			30									
REF2	2005	33891	Bypass graft, with other than vein, transcervical retrophary	0	6	0.098	0.062			20.00			323	70	20	20			173			40									
Current	2000	49561	Repair initial incisional or ventral hernia; incarcerated or str	090		0.074	0.044			15.38			352	45					100			30	2 1		1.0	1 1					
Current	2000	49566	Repair recurrent incisional or ventral hernia; incarcerated o	090		0.063	0.042			15.53			372	45					120			30	2 1		1.0	1 1					
Current	2011	49655	Laparoscopy, surgical, repair, incisional hernia (includes m	090		0.079	0.049			16.84			344	40	15	15			150			50			0.5	1 2					
Current	2007	49657	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.072	0.045			22.11			493	60	15	15			180			30	2 1		1.0	1 2					
Current	N/A	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhapl	YYY						N/A																					
Current	N/A	49999	Unlisted procedure, abdomen, peritoneum and omentum	YYY						N/A																					
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52												
SVY	2021	49622	Parastomal, Incarcerated/Strangulated	0	39	0.096	0.061	10.08	16.00	18.00	20.25	34.00	295	50	15	15	90	123	150	180	360	25	1				0	0	2	3	10
REC		49622	Median RVW	0		0.098	0.063			18.00			285	40	15	15			150			25	1								
																							Admitted							
REF1	2004	11008	Removal of prosthetic material or mesh, abdominal wall fo	ZZZ	83	0.083	0.083			5.00			60						60												
REF2	2002	35572	Harvest of femoropopliteal vein, 1 segment, for vascular re	ZZZ	12	0.114	0.114			6.81			60						60												
Current	2000	49565-22	Repair recurrent incisional or ventral hernia; reducible	090		0.058	0.040			12.37			312	45					100			30	1 1		1.0	1 1					
Current	2000	49566-22	Repair recurrent incisional or ventral hernia; incarcerated o	090		0.063	0.042			15.53			372	45					120			30	2 1		1.0	1 1					
Current	2007	49656-22	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.067	0.042			15.08			362	45	15	15			120			30	1 1		1.0	1 1					
Current	2007	49657-22	Laparoscopy, surgical, repair, recurrent incisional hernia (ir	090		0.072	0.045			22.11			493	60	15	15			180			30	2 1		1.0	1 2					
Current	N/A	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhapl	YYY						N/A																					
Current	N/A	49999	Unlisted procedure, abdomen, peritoneum and omentum	YYY						N/A																					
SVY	2021	49623	Removal of mesh or other prosthesis at the time of initial o	ZZZ	150	0.111	0.111	1.55	5.00	5.00	6.50	15.02	45				15	30	45	50	100						0	1	3	10	100
REC		49623	25th percentile RVW	ZZZ		0.111	0.111			5.00			45						45												
REF1	2018	49013	Preperitoneal pelvic packing for hemorrhage associated w	0	12	0.134	0.054			8.35			155	30	10	10			45			60									
REF2	2011	15273	Application of skin substitute graft to trunk, arms, legs, tota	0	8	0.093	0.035			3.50			100	40	10	10			20			20									
Current	N/A	49999	Unlisted procedure, abdomen, peritoneum and omentum	YYY						N/A																					
Current	1993	49568	Implantation of mesh or other prosthesis for open incisiona	ZZZ		0.094	0.094			4.88			52						52												
SVY	2021	15778	Implantation of absorbable mesh or other prosthesis for de	0	36	0.056	0.037	5.00	8.00	8.50	10.00	20.25	230	45	15	15	50	60	90	96	120	25	1				0	0	1	3	20
REC		15778	25th percentile RVW	0		0.055	0.038			8.00			213	40	3	15			90			25	1								
																							Inpatient							

ISSUE: Anterior Abdominal Hernia Repair
TAB: 9

			RVW			IWPUT			WPUT			Total	PRE				IMMD	Post SD			Facility
CPT	DESC	REC	25th	MED	75th	25th	MED	75th	25th	MED	75th	Time	EVAL	POSIT	SDW	MED	P-SD	33	32	31	Status
49591	Initial, Reduc, < 3cm	25th	6.27	8.00	10.00	0.113	0.151	0.196	0.058	0.074	0.093	108	25	3	15	45	20				same day
49613	Recurrent, Reduc, < 3cm	25th	7.75	11.00	12.03	0.105	0.159	0.176	0.057	0.081	0.089	135	30	10	15	60	20				same day
49592	Initial, I/S, < 3cm	25th	9.00	12.00	15.48	0.123	0.173	0.231	0.063	0.084	0.108	143	35	3	15	60	30			0	overnight
49614	Recurrent, I/S, < 3cm	25th	10.79	14.00	17.50	0.120	0.163	0.209	0.065	0.085	0.106	165	35	10	15	75	30			0	overnight
49593	Initial, Reduc, 3-10cm	25th	10.80	13.00	15.00	0.101	0.126	0.148	0.062	0.074	0.086	175	30	10	15	90	30			0	overnight
49615	Recurrent, Reduc, 3-10cm	25th	12.00	15.00	17.75	0.102	0.132	0.159	0.063	0.079	0.093	190	35	10	15	100	30			0	overnight
49621	Parastomal, Reduc	median	13.50	15.50	18.00	0.090	0.107	0.128	0.057	0.066	0.077	235	40	15	15	120	25			1	inpatient
49594	Initial, I/S, 3-10cm	median	14.00	16.65	20.00	0.099	0.121	0.149	0.062	0.074	0.089	225	35	15	15	120	40		0		overnight
49595	Initial, Reduc, > 10cm	median	14.88	17.00	19.00	0.105	0.123	0.140	0.065	0.074	0.083	230	40	15	15	120	40		0		overnight
49616	Recurrent, I/S, 3-10cm	median	16.50	18.50	22.28	0.094	0.109	0.136	0.060	0.067	0.081	275	40	15	15	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm	median	16.03	18.53	22.00	0.084	0.101	0.124	0.056	0.064	0.076	288	40	15	15	150	28		1		inpatient
49622	Parastomal, I/S	median	16.00	18.00	20.25	0.085	0.098	0.113	0.056	0.063	0.071	285	40	15	15	150	25		1		inpatient
49596	Initial, I/S, > 10cm	75th	17.94	20.00	24.24	0.088	0.101	0.127	0.058	0.065	0.078	310	40	15	15	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm	75th	20.00	24.00	25.00	0.089	0.111	0.117	0.060	0.072	0.075	335	40	15	15	180	30	1			inpatient
+49623	Removal of mesh	median	5.00	5.00	6.50	0.111	0.111	0.144	0.111	0.111	0.144	45				45					

			RVW			IWPUT			WPUT			Total	PRE				IMMD	Post SD			Facility
CPT	DESC			REC			REC			REC		Time	EVAL	POSIT	SDW	MED	P-SD	33	32	31	Status
49591	Initial, Reduc, < 3cm			6.27			0.113			0.058		108	25	3	15	45	20				same day
49613	Recurrent, Reduc, < 3cm			7.75			0.105			0.057		135	30	10	15	60	20				same day
49592	Initial, I/S, < 3cm			9.00			0.123			0.063		143	35	3	15	60	30			0	overnight
49614	Recurrent, I/S, < 3cm			10.79			0.120			0.065		165	35	10	15	75	30			0	overnight
49593	Initial, Reduc, 3-10cm			10.80			0.101			0.062		175	30	10	15	90	30			0	overnight
49615	Recurrent, Reduc, 3-10cm			12.00			0.102			0.063		190	35	10	15	100	30			0	overnight
49621	Parastomal, Reduc			15.50			0.107			0.066		235	40	15	15	120	25			1	inpatient
49594	Initial, I/S, 3-10cm			16.65			0.121			0.074		225	35	15	15	120	40		0		overnight
49595	Initial, Reduc, > 10cm			17.00			0.123			0.074		230	40	15	15	120	40		0		overnight
49616	Recurrent, I/S, 3-10cm			18.50			0.109			0.067		275	40	15	15	140	25		1		inpatient
49617	Recurrent, Reduc, > 10cm			18.53			0.101			0.064		288	40	15	15	150	28		1		inpatient
49622	Parastomal, I/S			20.25			0.113			0.071		285	40	15	15	150	25		1		inpatient
49596	Initial, I/S, > 10cm			24.24			0.127			0.078		310	40	15	15	160	25	1			inpatient
49618	Recurrent, I/S, > 10cm			25.00			0.117			0.075		335	40	15	15	180	30	1			inpatient
+49623	Removal of mesh			5.00			0.111			0.111		45				45					

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49591-49623, 15778
SPECIALTY SOCIETY(IES): ACS, SAGES, ASCRS
PRESENTER(S): Charles Mabry, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 04/2021

CPT	Long Descriptor	Global
49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible	000
49592	less than 3 cm, incarcerated or strangulated	000
49593	3 cm to 10 cm, reducible	000
49594	3 cm to 10 cm, incarcerated or strangulated	000
4959	greater than 10 cm, reducible	000
49596	greater than 10 cm, incarcerated or strangulated	000
49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible	000
49614	less than 3 cm, incarcerated or strangulated	000
49615	3 cm to 10 cm, reducible	000
49616	3 cm to 10 cm, incarcerated or strangulated	000
49617	greater than 10 cm, reducible	000
49618	greater than 10 cm, incarcerated or strangulated	000
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible	000
49622	incarcerated or strangulated	000
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	000

No inputs recommended for this facility only ZZZ code:

+49623	Removal of mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT	Vignette
49591	A 55-year-old male presents with a painful mass through the umbilicus that disappears in supine position He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.
49592	A 55-year-old male presents with a history of painful swelling in the umbilical region. Physical exam reveals an umbilical hernia that is tender and nonreducible by manual manipulation. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.
49593	A 60-year-old obese male with a prior laparotomy has developed a bulge in the midline incision. The defect has been increasing in size during follow-up. He has symptoms of pain

FACILITY DIRECT PE INPUTS

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CPT	Vignette
	and local tenderness. He has had no history of incarceration or bowel obstruction. Physical exam reveals a reducible incisional hernia. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.
49594	A 60-year-old obese male with a prior laparotomy has developed an incisional hernia in the midline incision. Over the past few months, the defect has become chronically protuberant. He reports increasing pain and discomfort. Physical exam reveals a hernia that is tender and nonreducible by manual manipulation. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.
4959	A 64-year-old obese male with a prior laparotomy has developed incisional hernias with defects of varying sizes at multiple points. He has symptoms of pain and tenderness at the sites. Physical exam reveals multiple reducible incisional hernias. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.
49596	A 64-year-old obese male with a prior laparotomy has developed incisional hernias with defects of varying sizes at multiple points. The defects have been increasing in size during follow-up with increasing symptoms. Physical exam reveals multiple tender and nonreducible incisional hernias. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.
49613	A 60-year-old obese male has a surgical history of a prior laparotomy with a resultant hernia in the incision. The prior hernia was repaired 5 years ago. He now has a bulge in the midepigastric area for 2 months that disappears when he lies down. Physical exam reveals a small recurrent reducible incisional hernia. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.
49614	A 60-year-old obese male has a surgical history of a prior laparotomy with a resultant hernia in the incision. The prior hernia was repaired 5 years ago. He now has a small bulge in the midepigastric area for 2 months that previously disappeared when supine. The bulge is now irreducible and tender. Physical exam reveals a small recurrent incarcerated incisional hernia. He undergoes hernia repair of a defect that is less than 3 cm with placement of mesh.
49615	A 60-year-old obese male presents with of a large bulge in midepigastric area that disappears when he lies down. His surgical history includes a prior laparotomy with resultant hernia that was repaired 5 years ago. Physical exam reveals a large recurrent reducible incisional hernia. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.
49616	A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size. Suddenly, the hernia is not reducible, and the mass is tender with severe, unremitting pain. He undergoes hernia repair of a defect that is 3 to 10 cm with placement of mesh.
49617	A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size but is reducible. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.
49618	A 60-year-old obese male presents with an irreducible mass in the midline of the abdomen. He has a history of a previous laparotomy with an incisional hernia from that operation that

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49591-49623, 15778
SPECIALTY SOCIETY(IES): ACS, SAGES, ASCRS
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CPT	Vignette
	was repaired 5 years ago. Over the course of the last few months, he has developed a recurrence that has been slowly increasing in size and is now tender and irreducible. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.
49621	A 70-year-old male with history of rectal cancer with subsequent abdominoperineal resection and end colostomy presents with a worsening bulge around his stoma when coughing, pain and discomfort around the stoma, and difficulty keeping the stoma appliance in place due to leakage. CT scan revealed small bowel in the hernia sac. He undergoes parastomal hernia repair with placement of mesh.
49622	A 70-year-old male with history of rectal cancer, colon resection and sigmoid colostomy presents with a worsening parastomal hernia associated with pain. The hernia cannot be reduced and a CT scan indicates incarcerated small bowel loops in the parastomal hernia sac. He undergoes parastomal hernia repair with placement of mesh.
15778	A 60-year-old obese male with a large abdominal wall defect as a result of necrotizing infection and extensive debridement of all involved skin, subcutaneous tissue, fascia, and muscle now undergoes delayed closure with implantation of absorbable mesh.

No inputs recommended for this facility only ZZZ code:

+49623	At the time of hernia repair, a 64-year-old obese male who had mesh placed with a prior hernia repair now requires removal of the mesh to allow for an adequate repair of a new hernia. Note: This is an add-on service. Only consider the additional work related to mesh removal.	**ZZZ**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   ACS, SAGES, and ASCRS Advisors reviewed the PE details for the current codes to develop a recommendation for the new codes

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Current codes used as reference

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   n/a

FACILITY DIRECT PE INPUTS

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

n/a

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

49591-49622

These 14 new anterior abdominal hernia repair codes are replacing 15 anterior abdominal hernia repair codes that have a 90-day global assignment.

When reviewing the details of the hernia codes that will be deleted, the specialties recognize that a vast majority of hernia repairs will be performed in the hospital, with very few cases performed in an ASC.

Of the cases performed in the hospital, the split between inpatient and outpatient will not be completely aligned with size of defect. For example, the second size group (3 to 10 cm) is still a wide variation in terms of postoperative care (overnight or admit). Similarly, very large hernias - over 10 cm - will all be inpatient, but there is variability in the length of stay depending on whether the defect is 12 cm or 25 cm.

The expert panel determined that a 0-day global would allow correct reporting of inpatient and outpatient postoperative work as medically necessary, without the need to create significantly more codes (eg, more sizes and separating incarcerated from strangulated) – similar to the 23 hysterectomy codes that include various sizes of uterus, various different approaches and various different bundled additional work.

As support of a 0-day global and the variability of postop work, the CMS DRG LOS MedPAR data for the 2021 IPPS Final Rule shows that even patients without CC/MCC, the LOS range is 1-5.

Table 7B - Medicare Prospective Payment System Selected Percentile Lengths of Stay; FY 2019 MedPAR Update - March 2020 Grouper V38 MS-DRGs - Correction Notice

MS_DRG	Number of Discharges	Arithmetic Mean LOS	10th pctl	25th pctl	Median	75th pctl	90th pctl
353 HERNIA PROCEDURES **EXCEPT** INGUINAL AND FEMORAL **WITH MCC**	2,743	7.69	**2**	4	**6**	10	**15**
354 HERNIA PROCEDURES **EXCEPT** INGUINAL AND FEMORAL **WITH CC**	7,265	4.52	**1**	2	**4**	6	**8**
355 HERNIA PROCEDURES **EXCEPT** INGUINAL AND FEMORAL **WITHOUT CC/MCC**	5,310	2.84	**1**	2	**2**	4	**5**

Changing the postoperative global payment package from 90-days to 0-days does not change the clinical staff preservice work. We strongly urge the PE Subcommittee to recognize this fact and to establish a pre-time clinical staff package for major surgical procedures that move from a 90-day to 0-day global.

CPT has recently defined "minor" and "major" surgery as:
Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These

terms are not defined by a surgical package classification.

We are recommending the following clinical staff preservice times for codes 49591-49622. These times are consistent will all major surgical procedures and the hernia repair procedures represented by 49591-49622 are all major surgery.

Activity	Clinical Staff Work	TIME
Complete pre-service diagnostic and referral forms	Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.	5
Coordinate pre-surgery services (including test results)	Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Enter and record all clinical updates in EHR.	20
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.	8
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.	20
Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission questions.	7

15778

The typical patient undergoing 15778 will have been in the hospital for many days to weeks. After resolution of the necrotizing infection and multiple debridements, mesh may be an option for closure. The pre-service clinical staff work will be limited to activities to coordinate the surgeon's schedule, timing of the procedure, arranging for supplies/equipment with the hospital and confirming approval with the payor. For these reasons, the recommendation for code 15778 is to crosswalk to the times assigned for emergent procedures.

Activity	Clinical staff work	TIME
Complete pre-service diagnostic and referral forms	Staff will ensure all diagnostic testing has been ordered and is available in the office medical record for the surgeon's review and that the procedure has been approved by the payor.	5
Coordinate pre-surgery services (including test results)	Staff will ensure collection and documentation of imaging/lab results, patient specific information and other relevant patient information, including conducting requisite pre-surgery assessment with the anesthesiologist, is available in the office medical record for the surgeon's review.	7
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.	4
Provide pre-service education/obtain consent		0
Complete pre-procedure phone calls and prescription	Staff confirms the surgeon's preoperative medication changes and new medication orders are documented in the facility and office medical records.	4

FACILITY DIRECT PE INPUTS

CPT CODE(S): 49591-49623, 15778
SPECIALTY SOCIETY(IES): ACS, SAGES, ASCRS
PRESENTER(S): Charles Mabry, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

b. Service period (includes pre, intra and post):

n/a

c. Post-service period:

49591 and 49613

The typical patient for 49591 and 49613 will be discharged on the same day of the procedure. Office clinical staff will assist with necessary post-discharge care via phone or electronically, such as: responding to patient/family questions about home activity restrictions; confirmation of discharge antibiotics if needed, and pain medication; coordination with other physicians and QHPs involved in the care of the patient for transfer of records; and transitioning discharge information to the surgeon's office medical record, including medication list, correspondence and imaging or lab results pending at discharge. The total time of 6 minutes is consistent with the total time for same-day outpatient work assigned a discounted 0.5 x 99238 (ie, 6 minutes).

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

FACILITY DIRECT PE INPUTS

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

n/a

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

n/a

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Suture removal pack was removed as not utilized on the day of the procedure.

FACILITY DIRECT PE INPUTS

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1	RUC Practice Expense Spreadsheet		CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	CURRENT	REC	REC	REC	REC	REC	REC	REC	REC	REC
2			49560	49561	49565	49566	49570	49572	49580	49582	49585	49587	49590	49652	49653	49654	49655	49656	49657	49591	49592	49593	49594	49595	49596	49613	49614	49615
3	Clinical Activity Code	Meeting Date: 04/2021 Revision Date (if applicable): Tab: 9 Specialty: ACS, SAGES, ASCRS	Repair initial incisional or ventral	Repair initial incisional or ventral	Repair recurrent incisional or ventral	Repair recurrent incisional or ventral	Repair epigastric hernia (eg, preperitone	Repair epigastric hernia (eg, preperitone	Repair umbilical hernia, younger	Repair umbilical hernia, younger	Repair umbilical hernia, age 5 years or	Repair umbilical hernia, age 5 years or	Repair spigelian hernia	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Initial, Reduc, < 3cm	Initial, I/S, < 3cm	Initial, Reduc, 3-10cm	Initial, I/S, 3-10cm	Initial, Reduc, > 10cm	Initial, I/S, > 10cm	Recurrent, Reduc, < 3cm	Recurrent, I/S, < 3cm	Recurrent, Reduc, 3-10cm
4		LOCATION	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility
5		GLOBAL PERIOD	090	090	090	090	090	090	090	090	090	090	090	090	090	090	090	090	090	000	000	000	000	000	000	000	000	000
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 61.29	$ 63.51	$ 63.51	$ 63.51	$ 61.29	$ 61.29	$ 61.29	$ 63.51	$ 61.29	$ 63.51	$ 61.29	$ 63.96	$ 78.53	$ 63.96	$ 78.53	$ 63.96	$ 78.53	$ 24.42	$ 22.20	$ 22.20	$ 22.20	$ 22.20	$ 22.20	$ 24.42	$ 22.20	$ 22.20
7		TOTAL CLINICAL STAFF TIME	129	135	135	135	129	129	129	135	129	135	129	135	162	135	162	135	162	66	60	60	60	60	60	66	60	60
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	6	12	12	12	6	6	6	12	6	12	6	12	12	12	12	12	12	0	0	0	0	0	0	0	0	0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	63	63	63	63	63	63	63	63	63	63	63	63	90	63	90	63	90	6	0	0	0	0	0	6	0	0
11		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ 47.73	$ 49.95	$ 49.95	$ 49.95	$ 47.73	$ 47.73	$ 47.73	$ 49.95	$ 47.73	$ 49.95	$ 47.73	$ 49.95	$ 59.94	$ 49.95	$ 59.94	$ 49.95	$ 59.94	$ 24.42	$ 22.20	$ 22.20	$ 22.20	$ 22.20	$ 22.20	$ 24.42	$ 22.20	$ 22.20
12		PRE-SERVICE PERIOD																										
13		Start: Following visit when decision for surgery/procedure made																										
14	CA001	Complete pre-service diagnostic and referral forms	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
15	CA002	Coordinate pre-surgery services (including test results)	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
16	CA003	Schedule space and equipment in facility	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
17	CA004	Provide pre-service education/obtain consent	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
18	CA005	Complete pre-procedure phone calls and prescription	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
19		End: When patient enters office/facility for surgery/procedure																										
20		SERVICE PERIOD																										
21		Start: When patient enters office/facility for surgery/procedure:																										
64	CA036	Discharge day management	6	12	12	12	6	6	6	12	6	12	6	12	12	12	12	12	12									
71		End: Patient leaves office/facility																										
72		POST-SERVICE PERIOD																										
73		Start: Patient leaves office/facility																										
74	CA037	Conduct patient communications																		6						6		
75	CA038	Coordinate post-procedure services																										
76		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
77		99211 16 minutes																										
78		99212 27 minutes	1	1	1	1	1	1	1	1	1	1	1	1	2	1	2	1	2									
79		99213 36 minutes	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1									
80		99214 53 minutes																										
81		99215 63 minutes																										
82	CA039	Post-operative visits (total time)	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	90.0	63.0	90.0	63.0	90.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
89		End: with last office visit before end of global period																										

	A	B	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1	**RUC Practice Expense Spreadsheet**		**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**CURRENT**	**REC**	**REC**	**REC**	**REC**	**REC**	**REC**	**REC**	**REC**	**REC**
2			**49560**	**49561**	**49565**	**49566**	**49570**	**49572**	**49580**	**49582**	**49585**	**49587**	**49590**	**49652**	**49653**	**49654**	**49655**	**49656**	**49657**	**49591**	**49592**	**49593**	**49594**	**49595**	**49596**	**49613**	**49614**	**49615**
3	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable):** **Tab: 9** **Specialty: ACS, SAGES, ASCRS**	Repair initial incisional or ventral	Repair initial incisional or ventral	Repair recurrent incisional or ventral	Repair recurrent incisional or ventral	Repair epigastric hernia (eg, preperitone	Repair epigastric hernia (eg, preperitone	Repair umbilical hernia, younger	Repair umbilical hernia, younger	Repair umbilical hernia, age 5 years or	Repair umbilical hernia, age 5 years or	Repair spigelian hernia	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Laparoscopy, surgical, repair,	Initial, Reduc, < 3cm	Initial, I/S, < 3cm	Initial, Reduc, 3-10cm	Initial, I/S, 3-10cm	Initial, Reduc, > 10cm	Initial, I/S, > 10cm	Recurrent, Reduc, < 3cm	Recurrent, I/S, < 3cm	Recurrent, Reduc, 3-10cm
4		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 61.29**	**$ 63.51**	**$ 63.51**	**$ 63.51**	**$ 61.29**	**$ 61.29**	**$ 61.29**	**$ 63.51**	**$ 61.29**	**$ 63.51**	**$ 61.29**	**$ 63.96**	**$ 78.53**	**$ 63.96**	**$ 78.53**	**$ 63.96**	**$ 78.53**	**$ 24.42**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 24.42**	**$ 22.20**	**$ 22.20**
7		**TOTAL CLINICAL STAFF TIME**	**129**	**135**	**135**	**135**	**129**	**129**	**129**	**135**	**129**	**135**	**129**	**135**	**162**	**135**	**162**	**135**	**162**	**66**	**60**	**60**	**60**	**60**	**60**	**66**	**60**	**60**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6**	**12**	**12**	**12**	**6**	**6**	**6**	**12**	**6**	**12**	**6**	**12**	**12**	**12**	**12**	**12**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**90**	**63**	**90**	**63**	**90**	**6**	**0**	**0**	**0**	**0**	**0**	**6**	**0**	**0**
90	**Supply Code**	**MEDICAL SUPPLIES**																										
91		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 12.79**	**$ 16.84**	**$ 12.79**	**$ 16.84**	**$ 12.79**	**$ 16.84**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
92	SA048	pack, minimum multi-specialty visit	2	2	2	2	2	2	2	2	2	2	2	2	3	2	3	2	3									
93	SA054	pack, post-op incision care (suture)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
95	**Equipment Code**	**EQUIPMENT**																										
96		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 0.77**	**$ 1.22**	**$ 1.74**	**$ 1.22**	**$ 1.74**	**$ 1.22**	**$ 1.74**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
97	EQ168	light, exam	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	90.0	63.0	90.0	63.0	90.0									
98	EF023	table, exam	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0	63.0															
99	EF031	table, power												63.0	90.0	63.0	90.0	63.0	90.0									
100																												

	A	B	AG	AH	AI	AJ	AK	AL	AM	AN
1	**RUC Practice Expense Spreadsheet**		**REC**	**REC**	**REC**	**REC**	**REC**	**CURRENT**	**REC**	**REC**
2			**49616**	**49617**	**49618**	**49621**	**49622**	**+49568**	**15778**	**+49623**
3	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable):** **Tab: 9** **Specialty: ACS, SAGES, ASCRS**	Recurrent, I/S, 3-10cm	Recurrent, Reduc, > 10cm	Recurrent, I/S, > 10cm	Parastomal, Reduc	Parastomal, I/S	**Implantation** of mesh or other prosthesis for	**Implantation** of absorbable mesh or other prosthesis for	**Removal** of mesh or other prosthesis at
4		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**ZZZ**	**000**	**ZZZ**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ -**	**$ 7.40**	**$ -**
7		**TOTAL CLINICAL STAFF TIME**	**60**	**60**	**60**	**60**	**60**	**0**	**20**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60**	**60**	**60**	**60**	**60**	**0**	**20**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ -**	**$ 7.40**	**$ -**
12		**PRE-SERVICE PERIOD**								
13		**Start: Following visit when decision for surgery/procedure made**								
14	CA001	Complete pre-service diagnostic and referral forms	5	5	5	5	5		5	
15	CA002	Coordinate pre-surgery services (including test results)	20	20	20	20	20		7	
16	CA003	Schedule space and equipment in facility	8	8	8	8	8		4	
17	CA004	Provide pre-service education/obtain consent	20	20	20	20	20		0	
18	CA005	Complete pre-procedure phone calls and prescription	7	7	7	7	7		4	
19		**End: When patient enters office/facility for surgery/procedure**								
20		**SERVICE PERIOD**								
21		**Start: When patient enters office/facility for surgery/procedure:**								
64	CA036	Discharge day management								
71		**End: Patient leaves office/facility**								
72		**POST-SERVICE PERIOD**								
73		**Start: Patient leaves office/facility**								
74	CA037	Conduct patient communications								
75	CA038	Coordinate post-procedure services								
76		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
77		99211 16 minutes								
78		99212 27 minutes								
79		99213 36 minutes								
80		99214 53 minutes								
81		99215 63 minutes								
82	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
89		**End: with last office visit before end of global period**								

	A	B	AG	AH	AI	AJ	AK	AL	AM	AN
1	**RUC Practice Expense Spreadsheet**		**REC**	**REC**	**REC**	**REC**	**REC**	**CURRENT**	**REC**	**REC**
2			**49616**	**49617**	**49618**	**49621**	**49622**	**+49568**	**15778**	**+49623**
3	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable):** **Tab: 9** **Specialty: ACS, SAGES, ASCRS**	Recurrent, I/S, 3-10cm	Recurrent, Reduc, > 10cm	Recurrent, I/S, > 10cm	Parastomal, Reduc	Parastomal, I/S	**Implantation** of mesh or other prosthesis for	**Implantation** of absorbable mesh or other prosthesis for	**Removal** of mesh or other prosthesis at
4		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**ZZZ**	**000**	**ZZZ**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ -**	**$ 7.40**	**$ -**
7		**TOTAL CLINICAL STAFF TIME**	**60**	**60**	**60**	**60**	**60**	**0**	**20**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60**	**60**	**60**	**60**	**60**	**0**	**20**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
90	**Supply Code**	**MEDICAL SUPPLIES**								
91		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
92	SA048	pack, minimum multi-specialty visit								
93	SA054	pack, post-op incision care (suture)	**0**	**0**	**0**	**0**	**0**			
95	**Equipment Code**	**EQUIPMENT**								
96		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
97	EQ168	light, exam								
98	EF023	table, exam								
99	EF031	table, power								
100										

April 26, 2021

Mark Synovec, MD
Chair, CPT Editorial Panel
American Medical Association
330 N. Wabash Avenue, Suite 39300
Chicago, IL 60611-5585

RE: January 2021 CPT Tab 18 / April 2021 RUC Tab 9

Dear Dr. Synovec:

As the RUC and CPT Advisors for the American College of Surgeons (ACS), Society of American Gastrointestinal Endoscopic Surgeons (SAGES), and American Society of Colon and Rectal Surgeons ASCRS), we request that the CPT Executive Committee consider an editorial change to the guidelines and code descriptor for new add-on code 49623 that was approved at the January 2021 CPT Panel meeting.

During RUC review at the April 2021 meeting, a concern was expressed that the intent of "how much mesh" needed to be removed to report 49623 was not clear. The stakeholder societies indicated that the intent was total or near total removal of the mesh. To clarify the intent of this code, we request two edits as shown on the attached page: (1) add the words "total or near total" to the guidelines; and (2) add the words "total or near total non-infected" to the 49623 code descriptor.

The words "total or near total" have been used by CPT previously (eg, see 43107, 43112, 43286, 43288, 48146, 48153), so this is not a precedent. With respect to adding "non-infected" to the code descriptor, it appears this was an inadvertent error since: (1) the guidelines stipulate removal of non-infected mesh; and (2) a parenthetical below code 49623 instructs what code to report for removal of "infected" mesh.

Thank you for consideration of this request. If you have any questions, please contact Ms. Jan Nagle at JNagle@facs.org.

Sincerely,

Samuel Smith, MD, FACS ACS CPT Advisor	William Harb, MD, FACS ASCRS CPT Advisor	John S. Roth, MD, FACS SAGES CPT Advisor
Charles Mabry, MD, FACS ACS RUC Advisor	Steven Sentovich, MD, FACS ASCRS RUC Advisor	Ketan Sheth, MD, FACS SAGES RUC Advisor

cc: Zachary Hochstetler
Sherry Smith

Anterior Abdominal Hernia Repair

Digestive System
Abdomen, Peritoneum, and Omentum
Repair
Hernioplasty, Herniorrhaphy, Herniotomy

Codes 49X01-49X12 describe repair of an anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian) by any approach (ie, open, laparoscopic, robotic). Codes 49X01-49X12 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired. For example, "Swiss cheese" defects (ie, multiple separate defects) would be measured from the superior most aspect of the upper defect to the inferior most aspect of the lowest defect. In addition, the hernia defect size should be measured prior to opening the hernia defect(s) (ie, during repair the fascia will typically retract creating a falsely elevated measurement).

When both reducible and incarcerated/strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated/strangulated. For example, one 2 cm reducible initial incisional hernia and one 4 cm incarcerated initial incisional hernias separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudad distance of 8 cm (49X04).

Inguinal, femoral, lumbar, omphalocele and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 59 as appropriate.

Codes 49X13, 49X14 describe repair of a parastomal hernia (initial or recurrent) by any approach (ie, open, laparoscopic, robotic). Code 49X13 is reported for repair of a reducible parastomal hernia and code 49X14 is reported for an incarcerated or strangulated parastomal hernia.

Implantation of mesh or other prosthesis, when performed, is included in 49X01-49X14 and may not be separately reported. For total or near total removal of non-infected mesh when performed, use 49623 in conjunction with 49X01-49X14. For removal of infected mesh, see 11004, 11005, 11006, 11008.

Measuring Total Length of Anterior Abdominal Hernia Defect(s)

Hernia measurements are performed either in the transverse or craniocaudal dimension. The total length of the defect(s) corresponds to the maximum width or height of an oval drawn to encircle the outer perimeter of all repaired defects. If the defects are not contiguous and are separated by greater than or equal to 10 cm of intact fascia, total defect size is the sum of each defect measured individually.

Codes 49X01-49X12 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.

●49X01	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible
●49X02	less than 3 cm, incarcerated or strangulated
●49X03	3 cm to 10 cm, reducible
●49X04	3 cm to 10 cm, incarcerated or strangulated

●49X05 greater than 10 cm, reducible

●49X06 greater than 10 cm, incarcerated or strangulated

●49X07 Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible

●49X08 less than 3 cm, incarcerated or strangulated

●49X09 3 cm to 10 cm, reducible

●49X10 3 cm to 10 cm, incarcerated or strangulated

●49X11 greater than 10 cm, reducible

●49X12 greater than 10 cm, incarcerated or strangulated

●49X13 Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, includes placement of mesh or other prosthesis, when performed; reducible

●49X14+ incarcerated or strangulated

●49623 Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)

(Use 49623 in conjunction with 49X01-49X14)

(For removal of infected mesh, use 11008)

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000*

April 2021

Orthoptic Training – Tab 10

CPT code 92065 was identified in October 2019 as Harvard Valued utilization over 30,000. The Workgroup requested action plans to examine this service. In January 2020, the RUC recommended that this service be referred to CPT May 2020. This service with an "and/or" connector should be two different codes given their different patient populations and techniques used for the treatment. For that reason, this code should go back to CPT for a descriptor edit as well as creation of separate codes. At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel again to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes to delineate when the training is provided directly by the physician/qualified healthcare professional (QHP) and when it is provided by a technician under the supervision of the physician/QHP. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for CPT 2023. In February 2021, the CPT Editorial Panel revised code 92065 and created a new code to describe this service under the supervision of a physician or qualified health care professional.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to support a change in physician work for CPT code 92065.The compelling evidence is based on documentation in the peer-reviewed ophthalmological literature that there have been changes in physician work due to new techniques, knowledge, and technology that have added to the complexity of orthoptic training.

The Convergence Insufficiency Treatment Trial (CITT) was an NEI-sponsored multi-center randomized clinical trial which compared traditional pencil push-up therapy with three additional treatments for symptomatic convergence insufficiency: (1) home-based computer vergence and accommodation exercises, (2) office-based, supervised vergence and accommodative therapy plus computer training with home reinforcement, and (3) office-based placebo therapy with home reinforcement. With results first published in 2008, the CITT demonstrated that office-based vergence/accommodative therapy with home reinforcement was statistically significantly more effective than placebo and each of the other treatment regimens studied in improving both the symptoms and clinical signs associated with symptomatic convergence insufficiency. This transformed orthoptic training methodology. Today's office-based training employs new training exercises and computer equipment/software that differ from those manual and mechanical devices in use in 1992 when the procedure was first valued in the Harvard study. The training exercises and computer equipment/software also differ from those in use in 2002, prior to publication of the CITT, when the PE was last updated to include computer and VDT software.

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Current therapy for non-strabismic accommodative and vergence disorders including convergence insufficiency involves highly specific, sequential, sensory-motor-perceptual stimulation paradigms and regimens. It incorporates purposeful, controlled, and scientifically based manipulations of target blur, disparity, and proximity, with the aim of normalizing the accommodative system, the vergence system, and their mutual interactions. In addition, other sources of sensory information, such as kinesthesia and audition correlated to the accommodative and vergence states (e.g., position, innervation, effort, etc.) can provide cue reinforcement. It involves oculomotor integration with the head (i.e., eye-head coordination), neck (i.e., proprioceptive information), limbs, and overall body, with information from the other sensory modalities, producing temporally efficient, coordinated behavior.

The RUC agreed that compelling evidence has been met due to a change in physician work because of new techniques, knowledge, and technology. However, it was noted that compelling evidence was not necessarily required considering the service is going to be performed only 45 percent of the time at the frequency it was done before, while 55 percent of the time it is going to be a PE-only service, resulting in a total reduction in work RVUs. That is, even though the value is increasing from the current work RVU of 0.37 to 0.71, the total expenditure will decrease. The estimate of the 45 percent and 55 percent split was considered tenuous, however, and the RUC proceeded with approval of compelling evidence.

92065 ***Orthoptic training; performed by a physician or other qualified health care professional***
CPT code 92065 involves the physician/QHP personally administering neurosensory and neuromuscular training activities to develop, rehabilitate and enhance visual skills and processing. The use of lenses, prisms, filters, specialized instruments, and computer programs is an integral part of the therapy protocol. The typical patient has convergence insufficiency resulting in discomfort, strain, blur, headache, diplopia and difficulty with reading and other near tasks. Exercises are taught to the patient by the physician/QHP, including physician review of the patient's understanding of the plan and ability to perform the exercises correctly.

The RUC reviewed the survey results from 34 ophthalmologists and optometrists and determined that the survey 25th percentile work RVU of 0.71 appropriately accounts for the physician work involved in this service. The RUC recommends 2 minutes pre-service time, 30 minutes intra-service time and 4 minutes post-service time. CPT code 92065 is not a time-based code; it is a training procedure that is reported only once a day, unlike therapy sessions that can be reported several times in 30-minute increments on a single day. Optometrists are the dominant specialty, with 97.4 percent of Medicare claims in 2019. They were also the dominant survey responders, with 73.5 percent of the responses. The recommendations are based on the entire survey dataset as a better reflection of the overall times and values for this code, including a median intra-service time of 30 minutes.

The RUC noted that the procedure is performed on the same day as an office or eye Evaluation and Management (E/M) visit 39 percent of the time and with a sensorimotor exam (CPT code 92060) 15 percent of the time, which includes pre- and post-service work like that of an office visit. Therefore, the survey pre- and post-times were reduced from 10 to 2 minutes to not duplicate any work provided with the E/M service. During the office visit or sensorimotor exam, the physician develops a treatment plan consisting of a sequence of neurosensory and neuromuscular activities for the patient. The survey post-time was reduced from 9 to 4 minutes. This time is required to record patient performance into the medical record, develop a treatment plan for the next training session, enter that plan into the medical record, and generate a letter to the referring physician.

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To justify a work RVU of 0.71, the RUC compared the survey code to the key reference service codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 2 minutes pre-service time, 15 minutes intra-service time and 3 minutes immediate post-service time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70, 2 minutes pre-service time, 11 minutes intra-service time and 3 minutes immediate post-service time) and noted that the intra-service times do not match and the survey code has both greater intra-service and total time than the reference services. The RUC also noted, however, that the survey code is closely bracketed by the work values of MPC code 99212 and MPC code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 2 minutes pre-service time, 20 minutes intra-service time and 4 minutes immediate post-service time).

For additional support, the RUC compared the survey code to HCPCS code G0108 *Diabetes outpatient self-management training services, individual, per 30 minutes* (work RVU = 0.90, 2 minutes pre-service time, 30 minutes intra-service time and 5 minutes immediate post-service time) and noted the G-code is also a training code with identical intra-service time, nearly identical total time, yet a higher work value. The RUC noted that the recommended value is less than the median of the 37 XXX global codes in the RUC database with work values assigned within the last 10 years and 30 minute intra-service time (range 0.55 to 4.00, median 1.48 work RVUs). The RUC concluded that CPT code 92065 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.71 for CPT code 92065.**

92066 *Orthoptic training; under supervision of a physician or other qualified health care professional*
The new CPT code 92066 specifies training under supervision of a physician or other qualified health professional. The code has practice expense (PE) inputs only and was not surveyed for physician work. This PE-only code requires identical work and intra-service time as code 92065 but with a different health care professional, typically the technician, L038A *COMT/COT/RN/CST*, performing the service; thus, there are 30 minutes allocated to CA021 *Perform procedure/service---NOT directly related to physician work time.* Only one session per day is reported. The anticipated course of treatment is 1-2 sessions per week over a three-month period based upon the Convergence Insufficiency Treatment Trial (CITT).

The PE Subcommittee thoroughly reviewed the practice expense recommendations for the companion codes and approved the inputs with few modifications. For the medical supply inputs, the PE Subcommittee determined that they are not redundant and are disposable. There was one adjustment to supply item SK057 *Paper, laser* to accurately reflect the type of paper that is utilized for the patient to be working on cheiroscope and other visual motor skills. The updates to equipment reflect new changes in management of convergence insufficiency. The equipment location has changed from EL006 *lane, screening (oph)* to a room with table and 4 chairs to reflect the typical practice more accurately. The time applied for EF043 *Set of 8 chairs* was reduced by half to reflect the use of 4 chairs during the activities rather than the full 8 chairs. The PE Subcommittee recommends two new equipment inputs for this service, Pro Vision Therapy Starter System Model VTSSP and Sanet Vision Integrator display/software. The starter system contains several devices to stimulate fusion/convergence. Various components of this system are used as part of training for these vision activities. It is entirely reusable and thus considered as an equipment input for valuation. EQ232 *stereo trainer*

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(wheatstone) was removed to avoid duplication with the contents of the starter system. The Sanet Vision Integrator display/software is used as part of visual activities to address near acuity and depth perception issues. This replaces ED009 *computer and VDT and software* which was a more generic equipment previously included when the code was initially valued. Two paid invoices are included with this recommendation for these items. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for CPT codes 92066 and 92065.**

New Technology
CPT codes 92066 and 92065 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Ophthalmology Special Ophthalmological Services				
▲92065	D1	Orthoptic ~~*and/or pleoptic*~~ training~~*, with continuing medical direction and evaluation*~~; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066, *0687T, 0688T*, when performed on the same day)	XXX	0.71
●92066	D2	under supervision of a physician or other qualified health care professional (Do not report 92066 in conjunction with 92065*, 0687T, 0688T,* when performed on the same day)	XXX	0.00 (PE Only)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92065 Tracking Number D1 Original Specialty Recommended RVU: **0.71**
Presented Recommended RVU: **0.71**
Global Period: XXX Current Work RVU: **0.37** RUC Recommended RVU: **0.71**

CPT Descriptor: Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066, 0687T, 0688T, when performed on the same day)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female is referred for orthoptic training by a physician or other qualified health care professional to address convergence insufficiency issues after a concussion.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Details of the treatment plan are discussed with the patient. The patient is brought into the treatment room.

Description of Intra-Service Work: The patient is positioned before specialized instruments which allow the systematic application of lenses, prisms and angular disparity designed to address the ocular motor defect and to treat the dysfunction. Prescribed treatment regimens include a series of interventions during the treatment period including convergence exercises using an accommodative target of letters, numbers, or pictures; vergence exercises with applied base in or base out prism; jump to near convergence training on a Brock string; stereogram convergence exercises; and 3-D vergence demand exercises applied with an interactive video display. The patient demonstrates understanding to the physician or other QHP by proper performance of each of the prescribed exercises.

Description of Post-Service Work: Patient performance on each instrument and activity addressed during the session is evaluated and entered into the medical record. A treatment plan for the next orthoptic training session is developed and entered into the medical record. A report to the referring provider is generated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Charles Fitzpatrick, OD (AOA)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO), American Optometric Association (AOA)					
CPT Code:	92065					
Sample Size:	2302	**Resp N:**	34			
Description of Sample:	Random sample of US practicing members of AAO and AOA					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**13.00**	175.00	2250.00
Survey RVW:	0.07	0.71	**0.93**	0.98	110.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	19.25	**30.00**	45.00	60.00

Immediate Post Service-Time:	**8.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	92065	**Recommended Physician Work RVU: 0.71**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**4.00**	**0.00**	**4.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**Other**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**Other**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.70	**Other**	10,729,531

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93015	XXX	0.75	**Other**	999,644

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
G0108	XXX	0.90	**Other**

CPT Descriptor Diabetes outpatient self-management training services, individual, per 30 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 55.8 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 92065	Top Key Reference CPT Code: 99202	2nd Key Reference CPT Code: 99212
Median Pre-Service Time	2.00	2.00	2.00
Median Intra-Service Time	30.00	15.00	11.00
Median Immediate Post-service Time	4.00	3.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**36.00**	**20.00**	**16.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	16%	16%	42%	26%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	21%	53%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	26%	63%
Physical effort required	5%	5%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	32%	37%	32%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	50%	13%	38%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	50%	25%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	50%	38%
Physical effort required	0%	38%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	50%	25%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 92065, *Orthoptic training performed by a physician or other qualified health care professional (do not report 92065 in conjunction with 92066, 0687T, 0688T when performed on the same day)* is an XXX code that was flagged by a screen for Harvard-valued procedures with utilization over 30,000. The code was taken to the CPT Editorial Panel to remove "and/or pleoptic" and "with continuing medical direction and evaluation" from the descriptor in order to update the service to current practice. It was then surveyed for the October 2020 meeting. Survey results indicated that respondents were valuing two separate services: training by the physician and training by a technician under supervision of the physician.

The RUC valuation was deferred so that the code could be taken to CPT to create separate codes for each service. CPT 92065 now specifies that training is performed by a physician or other qualified health care professional. A new CPT code, 92066, specifies training under supervision of a physician or other qualified health professional. The new code has PE only and was not surveyed for physician work. Survey results and work value recommendations are presented for CPT 92065.

The procedure is performed on the same day as an office visit 33% of the time and with a sensorimotor exam (CPT 92060) 18% of the time. We considered the sensorimotor exam similar enough to an office visit to treat the surveyed code as typically performed with a same-day office visit, and reduced survey pre- and post-times to eliminate duplicative work. During the office visit or sensorimotor exam, the physician develops a treatment plan consisting of a sequence of neurosensory and neuromuscular activities for the patient.

The intraservice work of CPT 92065 consists of the provider personally administering neurosensory and neuromuscular training activities to develop, rehabilitate and enhance visual skills and processing. The use of lenses, prisms, filters, specialized instruments, and computer programs is an integral part of the therapy protocol. The goals of orthoptic treatment are to achieve desired visual outcomes, alleviate signs and symptoms, meet the patient's needs and improve the patient's quality of life. The typical patient has convergence insufficiency resulting in discomfort, strain, blur, headache, diplopia and difficulty with reading and other near tasks. Exercises are taught to the patient by the provider, including physician review of the patient's understanding of the plan and ability to perform the exercises correctly.

COMPELLING EVIDENCE

There is compelling evidence to support an increase in the work value of CPT 92065, which also is supported by the survey results. The compelling evidence is based documentation in the peer-reviewed ophthalmological literature that there have been changes in physician work due to new techniques, knowledge, and technology that have added to the complexity of the training.

Change in Physician Work Due to New Techniques, Knowledge, and Technology

The Convergence Insufficiency Treatment Trial (CITT) was an NEI-sponsored multi-center randomized clinical trial which compared traditional pencil push-up therapy with three additional treatments for symptomatic convergence insufficiency: (1) home-based computer vergence and accommodation exercises, (2) office-based, supervised vergence and accommodative therapy plus computer training with home reinforcement, and (3) office-based placebo therapy with home reinforcement. With results first published in 2008, the CITT demonstrated that office-based vergence/accommodative therapy with home reinforcement was statistically significantly more effective than placebo and each of the other treatment regimens studied in improving both the symptoms and clinical signs associated with symptomatic convergence insufficiency.[1-7] This transformed orthoptic training methodology. Today's office-based training employs new training exercises and computer equipment/software that differ from those manual and mechanical devices in use in 1992 when the procedure was first valued using Hsaio's methodology. They also differ from those in use in 2002, prior to publication of the CITT, when the PE was last updated to include computer and VDT software.

Current therapy for nonstrabismic accommodative and vergence disorders including convergence insufficiency involves highly specific, sequential, sensory-motor-perceptual stimulation paradigms and regimens. It incorporates purposeful, controlled, and scientifically based manipulations of target blur, disparity, and proximity, with the aim of normalizing the accommodative system, the vergence system, and their mutual interactions. In addition, other sources of sensory information, such as kinesthesia and audition correlated to the accommodative and vergence states (e.g., position, innervation, effort, etc.) can provide cue reinforcement. It involves oculomotor integration with the head (i.e., eye-head coordination), neck (i.e., proprioceptive information), limbs, and overall body, with information from the other sensory modalities, producing temporally efficient, coordinated behavior.

SURVEY RESULTS

A survey was sent to a random selection of American Academy of Ophthalmology (AAO) and the American Optometric Association (AOA). There were 34 responses, 91% of whom found the vignette to be typical. The median WRVU was 0.93, and the 25th percentile was 0.71. The current value of the code is 0.37 WRVU. The median IST was 30 minutes, with 10 minutes of pre-service evaluation time and 9 minutes of immediate post-service time.

The survey data were analyzed by subgroup according to specialty (ophthalmology vs. optometry), whether the respondent performed the service or not, and excluding the three outliers who responded that they performed the service over 1,000 times annually. The subgroup data are listed in separate rows of the revised Summary Spreadsheet.

There was a significant difference in the 25th percentile WRVU between the OD and MD subgroups: 0.90 for ODs and 0.55 for MDs. The combined data 25th percentile WRVU is 0.71.

The median IST was also different between the OD and MD subgroups: 40 minutes for ODs and 10 minutes for MDs. The overall median IST is 30 minutes.

The panel considered the possibility of reporting the service with an IST as short as 10 minutes. CPT 92065 is not a time-based code. It is a training procedure that is reported only once a day, unlike therapy sessions that can be reported several times in 30-minute increments on a single day.

Optometrists are the dominant specialty, with 97.4% of claims in 2019. They were also the dominant survey responders, with 73.5% of the responses. The typical optometric training session is 40 minutes long. Some sessions may be shorter if the patient is too fatigued to continue, and some may be longer, but the 25th to 75th percentile range of IST was 30 to 45 minutes. The IST for 75% of the OD cases is 30 minutes.

Ophthalmologists accounted for 2.2% of claims (723) in 2019, and for only 9 survey responses. Although the median IST for MDs was 10 minutes, only about 350 claims would be expected from MDs with an IST of 10 minutes or less.

This might argue for use of the OD data exclusively. The panel chose to use the combined data as a better reflection of the overall times and values for this code, and to avoid over-valuing it.

Deleting the data from zero performers resulted in no significant difference in median IST or 25th percentile WRVU between performers and the full data set. The IST is 30 min in both groups. The 25th percentile WRVU is 0.71 for the entire data set and 0.69 for those who reported performing the procedure.

Eliminating the 3 hyperperformers did not change the analysis significantly.

We therefore based our recommendations on the entire data set. This includes a median IST of 30 minutes which is appropriate for training administered by the provider rather than delegated to a technician, a median work value of 0.93, and a 25th percentile work value of 0.71.

The top key reference service, chosen by 56% of respondents, was CPT 99202, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter,* (RUC 2019), with a WRVU of 0.93, an IST of 15 minutes, and a total time of 20 minutes. The second reference service, chosen by 24% of respondents, was CPT 99212, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (RUC 2019), with a WRVU of 0.70, an IST of 11 minutes, and total time of 16 minutes. The majority of respondents ranked the surveyed code higher or much higher than the top key reference service on overall intensity and complexity and all of the submeasures. Of the 24% who chose the second key reference service, half ranked the surveyed code somewhat lower than the second key reference service on overall intensity and complexity and psychological stress, and identical or higher on the other submeasures.

We treated the service as typically provided with a same-day office visit because it is performed 33% of the time with an office visit and 18% of the time with a sensorimotor exam (CPT 92060), which includes pre- and post-service work similar to that of an office visit. We therefore reduced the pre-time from the survey value of 10 minutes to 2 minutes. This time is required to review the plan with the patient and bring them to the treatment room. We reduced the survey post-time from 9 minutes to 4 minutes. This time is required to record patient performance into the medical record, develop a treatment plan for the next training session, enter that plan into the medical record, and generate a letter to the referring provider. The total time for the procedure is 36 minutes, with a 30-minute IST.

We recommend a work value equal to the survey's 25th percentile value: 0.71 WRVU. This is less than the median of the 37 XXX CPT codes in the RUC database with work values assigned within the last 10 years and 30-minute ISTs (median 1.48 WRVU, range 0.55 to 4.00 WRVU).

Although we are not recommending a crosswalk to this code, the recommended value is supported by HCPCS code G0108, *Diabetes outpatient self-management training services, individual, per 30 minutes* (RUC 2017). This is also a training code

with an identical 30-minute IST, an almost-identical 37-minute total time, and a higher work value of 0.90 WRVU. There is additional support from CPT 88365, *In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure* (RUC 2014) and CPT 88368, *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure* (RUC 2014), both of which have 30-minute ISTs and higher valuations at 0.88 WRVU.

We recommend the survey 25th percentile work value of 0.71 WRVU for CPT 92065 with times of 2/30/4 and a total time of 36 minutes.

References

1. Convergence Insufficiency Treatment Trial (CITT) Study Group. The convergence insufficiency treatment trial: design, methods, and baseline data. Ophthalmic Epidemiol. 2008;15:24-36.
2. Convergence Insufficiency Treatment Trial (CITT) Study Group. A randomized clinical trial of treatments for convergence insufficiency in children. Arch Ophthalmol. 2008;126:1336-1349.
3. Convergence Insufficiency Treatment Trial Study Group. Long-term effectiveness of treatments for symptomatic convergence insufficiency in children. Optom Vis Sci. 2009;86:1096-103.
4. Scheiman M, Kulp MT, Cotter S, Mitchell GL, Gallaway M, Boas M, Coulter R, Hopkins K, Tamkins S; Convergence Insufficiency Treatment Trial Study Group. Vision therapy/orthoptics for symptomatic convergence insufficiency in children: treatment kinetics. Optom Vis Sci. 2010;87:593-603.
5. Scheiman M, Cotter S, Kulp MT, Mitchell GL, Cooper J, Gallaway M, Hopkins KB, Bartuccio M, Chung I; Convergence Insufficiency Treatment Trial Study Group. Treatment of accommodative dysfunction in children: results from a randomized clinical trial. Optom Vis Sci. 201;88:1343-52.
6. Borsting E, Mitchell GL, Kulp MT, Scheiman M, Amster DM, Cotter S, Coulter RA, Fecho G, Gallaway MF, Granet D, Hertle R, Rodena J, Yamada T; CITT Study Group. Improvement in academic behaviors after successful treatment of convergence insufficiency. Optom Vis Sci. 2012;89:12-8.
7. Barnhardt C, Cotter SA, Mitchell GL, Scheiman M, Kulp MT; CITT Study Group. Symptoms in children with convergence insufficiency: before and after treatment. Optom Vis Sci. 2012;89:1512-20.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Typically billed with an office visit or sensorimotor measurements.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global Period	Work RVU	Pre	Intra	Post	% Billed Together
4.	92060	XXX	0.69	5	30	5	18.3%
5.	92012	XXX	0.92	5	15	5	12.8%
6.	99213	XXX	0.92	5	15	5	12.4%
7.	97530	XXX	0.44	2	15	2	10.7%
8.	97110	XXX	0.45	2	15	2	8.0%
9.							62.2%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92065

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 2000 Percentage 3.33 %

Specialty Optometry Frequency 58000 Percentage 96.66 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 1000 Percentage 5.00 %

Specialty Optometry Frequency 19000 Percentage 95.00 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92065

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Orthoptic Training

TAB: 10

source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluatic	2019	19	0.047	0.047			0.93			20	2					15			3					
2nd REF	99212	XXX	Office or other outpatient visit for the evaluatic	2019	8	0.044	0.044			0.70			16	2					11			3					
CURRENT	92065	XXX	Orthoptic and/or pleoptic training, with continu	N/A - Harvard		0.022	0.022			0.37			17						17								
SVY	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do		34	0.017	0.019	0.07	0.71	0.93	0.98	110.00	49	10			3	19	30	45	60	9	0	2	13	175	2250
SVY - OD	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do		25	0.013	0.016	0.07	0.90	0.95	0.98	110.00	59	10			5	30	40	45	60	9	0	2	12	200	2250
SVY - MD	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do		9	0.034	0.027	0.25	0.55	0.70	0.90	2.00	26	8			3	6	10	22	30	8	0	5	20	24	2000
SVY - PERFORMERS	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066, 058XT, 059XT, when performed on the same		28	0.018	0.019	0.07	0.69	0.92	0.98	110.00	47.5	9.5			3	18	30	45	60	8	1	7	20	213	2250
SVY - NON-PERFORMERS	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066,		6	0.013	0.017	0.87	0.95	0.96	0.97	45.00	58	11			12	24	35	44	60	12	0	0	0	0	0
SVY - EXCLUDE PERFORMERS >1000	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066, 058XT, 059XT, when performed on the same day)		31	0.017	0.019	0.07	0.70	0.93	0.98	45.00	49	10			3	20	30	45	60	9	0	2	12	72	557
REC	92065	XXX	Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 92066, 058XT, 059XT, when performed on the same			0.019	0.020			0.71			36	2					30			4					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_92066_**

SPECIALTY SOCIETY(IES):_AAO, AOA__

PRESENTER(S):_ David Glasser, Ankoor Shah, Charlie Fitzpatrick, Harvey Richman_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
92066	Orthoptic training; under supervision of a physician or other qualified health care professional	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
92066	A 25-year old female is referred for orthoptic training to address convergence insufficiency issues after concussion

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other healthcare providers who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The healthcare providers on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   This code is new and 92065 which is the same procedure when performed by the physician is used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   New Code; We anticipate it being used similar to 92065. The answers provided for 92065 are listed below:

   No.
   No.
   However, because the procedure is performed on the same day as an office visit 33% of the time, and is also reported with a sensorimotor exam (CPT 92060) 18% of the time. We considered the sensorimotor exam similar enough to an office visit to treat the surveyed code as typically performed with a same-day office visit.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

New Code: We anticipate findings similar to 92065 whose findings are below:

Optometry (97%)
Non-facility Performance (100%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

During the service period multiple activities (visual exercises) are taught to the patient and these activities are repeated to ensure proper performance, and adjust/enhance difficulties during the testing period. The person conducting all of this work varies by code 92065 (physician) and 92066 (technician).

Granular detail is provided below. Standard input times used for pre, intra, and post activities. Survey times used for intra-service activities.

Pre: (Standard Inputs)
Line CA011 – The technician provides education and obtains consent for the procedure.
Line CA013 – The technician prepares the room, equipment, and supplies. During this time, typically the first activity is setup for the patient. Since anywhere between 6-8 activities (visual exercises) are taught they are setup in succession during the intra-service period for the remaining activities.
Line CA016 – The patient is positioned and height of the table is adjusted to begin the first activity.

Intra: (Survey Time of Physician Time Input)
Line CA021 – The technician performs the following activities. The patient is positioned before specialized instruments which allow the systematic application of lenses, prisms and angular disparity designed to address the ocular motor defect and to treat the dysfunction. Prescribed treatment regimens include a series of interventions during the treatment period including convergence exercises using an accommodative target of letters, numbers, or pictures; vergence exercises with applied base in or base out prism; jump to near

convergence training on a Brock string; stereogram convergence exercises; and 3D vergence demand exercises applied with an interactive video display. The patient demonstrates understanding to the technician by proper performance of each of the prescribed exercises.

Post: (Standard Inputs)
Line CA024 – The technician will clean the room and pack up the equipment utilized.
Line CA031 – The technician will review with the healthcare provider the patient's performance on the activities, before the provider comes up with a finalize plan.
Line CA035 - Based on the providers plan, "homework" packets of the exercises needed to be performed are obtained and given to the patient.

c. Post-service period:

Line CA038 – Removed

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

The patient is positioned before specialized instruments which allow the systematic application of lenses, prisms and angular disparity designed to address the ocular motor defect and to treat the dysfunction. Prescribed treatment regimens include a series of interventions during the treatment period including convergence exercises using an accommodative target of letters, numbers, or pictures; vergence exercises with applied base in or base out prism; jump to near convergence training on a Brock string; stereogram convergence exercises; and 3D vergence demand exercises applied with an interactive video display. The patient demonstrates understanding to the technician by proper performance of each of the prescribed exercises.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

No.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Supplies:
Line SG043 Dressing, eye pad – still used and kept in supply list
Line SK057 Paper, laser - still used for patient to be working on cheiroscope and other visual motor skills and kept in supply list
Line SJ053 Swab-pad, alcohol – Was omitted in error, but is utilized to sterilize equipment prior to patient use

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Invoices will be provided for new supplies with standard/default formulas.

Pro Vision Therapy Starter System Model VTSSP – contains a number of devices to stimulate fusion/convergence. Various components of this system are used as part of training for these vision activities. Invoice attached. This is entirely reusable and thus considered as an equipment for valuation.

Sanet Vision Integrator display/software This is used as part of visual activities to address near acuity and depth perception issues. This *replaces* the computer VDT and software which was a more generic equipment previously included when the code was initially valued.

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

5 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment. Time included for all supplies reflects time room occupied for the procedure. For the chairs listed as supplies we listed half the time the room is occupied in order to price the use of 4 (rather than 8 chairs) in the room.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Line 122 NEW Sanet Vision Integrator display/software – This is used as part of visual activities to address near acuity and depth perception issues. This *replaces* the computer VDT and software which was a more generic equipment previously included when the code was initially valued.
Line 123 NEW Pro Vision Therapy Starter System Model VTSSP – This system includes various devices to test and stimulate fusion and is integral for many of the visual activities performed
Line EQ165 Lens set, trial – Trial lenses allow for the increasing/decreasing the difficulties of the activities being performed
Line EQ232 Stereo Trainer – Removed
Line EQ236 Telebinocular, ophthalmic – Used as part of the visual activities. Time included reflects time room occupied for the procedure.
Line EQ049 Anomaloscope, diagnositc– *Removed* – No longer the typically used.
Line ED009 Computer and VDT and software – **Removed and replaced with Sanet Vision Integrator which is a more specific type of device utilized** as part of the visual activities. Time included reflects time room occupied for the procedure.
Line EL006 lane, screening (oph) – *Removed* – No longer typically performed in this room.
Line EF030 table, power – *Added* – A room with a power table and 4 chairs was added in place of an exam room as this is more typical
Line EF043 chairs (set of 8) – The time applied for the chairs was cut in half, to reflect the use of 4 chairs during the activities rather than the full 8 chairs.

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

The updates to equipment reflect new changes in management of convergence insufficiency. Moreover, the equipment location (exam room to a room with table and 4 chairs) reflects the current typical practice.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

For PLI information the best crosswalk is 92065 as the procedure is identical but performed by a technician. However since this code is being surveyed at this meeting alternative codes are below.

92083 would be an alternative if 92065 cannot be utilized.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to

the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

The changes in **RED** were made when submitting the amended spreadsheet. The changes in **GREEN** were the additional changes made AFTER the PE Meeting. The same color coding is used in PE spreadsheet.

1. Changed the type of paper utilized from SK059 to SK057. This paper more accurately reflects the type of paper used.
2. Changed Computer VDT and software (the more generic equipment input) to zero and instead put in a specific device, the Sanet Vision Integrator display/software as the device used in the plurality of cases. An invoice has been provided for this system.

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_92065_**

SPECIALTY SOCIETY(IES):_AAO, AOA__

PRESENTER(S):_ David Glasser, Ankoor Shah, Charlie Fitzpatrick, Harvey Richman_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
92065	Orthoptic training; performed by a physician or other qualified health care professional	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
92065	A 25-year old female is referred for orthoptic training to address convergence insufficiency issues after concussion

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other healthcare providers who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The healthcare providers on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No.
   No.
   However, because the procedure is performed on the same day as an office visit 33% of the time, and is also reported with a sensorimotor exam (CPT 92060) 18% of the time. We considered the sensorimotor exam similar enough to an office visit to treat the surveyed code as typically performed with a same-day office visit.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Optometry (97%)
   Non-facility Performance (100%)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

During the service period multiple activities (visual exercises) are taught to the patient and these activities are repeated to ensure proper performance, and adjust/enhance difficulties during the testing period. The person conducting all of this work varies by code 92065 (physician) and 92066 (technician). Granular detail is provided below. Standard input times used for pre, intra, and post activities. Survey times used for intra-service activities. **Pre:** (Standard Inputs) Line CA011 – The technician provides education and obtains consent for the procedure. Line CA013 – The technician prepares the room, equipment, and supplies. During this time, typically the first activity is setup for the patient. Since anywhere between 6-8 activities (visual exercises) are taught they are setup in succession during the intra-service period for the remaining activities. Line CA016 – The patient is positioned and height of the table is adjusted to begin the first activity. **Intra:** (Survey Time of Physician Time Input) Line CA020 – Removed **Post:** (Standard Inputs) Line CA024 – The technician will clean the room and pack up the equipment utilized. Line CA031 – Removed Line CA035 - Based on the providers plan, "homework" packets of the exercises needed to be performed are obtained and given to the patient.

   c. Post-service period:

Line CA038 – Removed and moved to Line CA035

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

    The physician alone is performing the intraservice work.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

    Does not apply.

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

    N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

    No.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

    Supplies:
    Line SG043 Dressing, eye pad – still used and kept in supply list
    Line SK057 Paper, laser - still used for patient to be working on cheiroscope and other visual motor skills and kept in supply list
    Line SJ053 Swab-pad, alcohol – Was omitted in error, but is utilized to sterilize equipment prior to patient use

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Invoices will be provided for new supplies with standard/default formulas.

Pro Vision Therapy Starter System Model VTSSP – contains a number of devices to stimulate fusion/convergence. Various components of this system are used as part of training for these vision activities. Invoice attached. This is entirely reusable and thus considered as an equipment for valuation.

Sanet Vision Integrator display/software This is used as part of visual activities to address near acuity and depth perception issues. This *replaces* the computer VDT and software which was a more generic equipment previously included when the code was initially valued.

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

5 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment. Time included for all supplies reflects time room occupied for the procedure. For the chairs listed as supplies we listed half the time the room is occupied in order to price the use of 4 (rather than 8 chairs) in the room.

Line 122 NEW Sanet Vision Integrator display/software – This is used as part of visual activities to address near acuity and depth perception issues. This *replaces* the computer VDT and software which was a more generic equipment previously included when the code was initially valued.
Line 123 NEW Pro Vision Therapy Starter System Model VTSSP – This system includes various devices to test and stimulate fusion and is integral for many of the visual activities performed
Line EQ165 Lens set, trial – Trial lenses allow for the increasing/decreasing the difficulties of the activities being performed
Line EQ232 Stereo Trainer – Removed
Line EQ236 Telebinocular, ophthalmic – Used as part of the visual activities. Time included reflects time room occupied for the procedure.
Line EQ049 Anomaloscope, diagnositc– *Removed* – No longer the typically used.
Line ED009 Computer and VDT and software – **Removed and replaced with Sanet Vision Integrator which is more specific type of device utilized** as part of the visual activities. Time included reflects time room occupied for the procedure.
Line EL006 lane, screening (oph) – *Removed* – No longer typically performed in this room.
Line EF030 table, power – *Added* – A room with a power table and 4 chairs was added in place of an exam room as this is more typical
Line EF043 chairs (set of 8) – The time applied for the chairs was cut in half, to reflect the use of 4 chairs during the activities rather than the full 8 chairs.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

The updates to equipment reflect new changes in management of convergence insufficiency. Moreover, the equipment location (exam room to a room with table and 4 chairs) reflects the current typical practice.
30 minutes of intraservice time while the physician is actually performing the training activities are included in the determining total equipment time. Ie we used the standard formula times to calculate equipment time, and then added the 30 minutes that the physician is using the equipment to determine the complete amount of time.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

The changes in **RED** were made when submitting the amended spreadsheet. The changes in **GREEN** were the additional changes made AFTER the PE Meeting. The same color coding is used in PE spreadsheet.

1. Changed the type of paper utilized from SK059 to SK057. This paper more accurately reflects the type of paper used.
2. Changed Computer VDT and software (the more generic equipment input) to zero and instead put in a specific device, the Sanet Vision Integrator display/software as the device used in the plurality of cases. An invoice has been provided for this system.

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**CPT Code 92065**		**CPT Code 92065**		**CPT Code 92066**	
3		***RUC Collaboration Website***				Orthoptic and/or pleoptic training, with continuing medical direction and evaluation		Orthoptic training; performed by a physician or other qualified health care professional (Do not		Orthoptic training; under supervision of a physician or other qualified health care professional	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 10 Specialty: AAO, AOA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 26.63**	**$ -**	**$ 6.31**	**$ -**	**$ 18.47**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**48.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**46.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 18.24**	**$ -**	**$ 3.80**	**$ -**	**$ 15.96**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CST	0.38						
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CST	0.38						
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST	0.38						
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	0.38						
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CST	0.38						
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CST	0.38						
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CST	0.38						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CST	0.38						
23			L038A	COMT/COT/RN/CST	0.38						
26		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	~~Greet patient, provide gowning, ensure appropriate medical records are available~~	L038A	COMT/COT/RN/CST	0.38	2					
34	CA010	Obtain vital signs	L038A	COMT/COT/RN/CST	0.38						
35	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CST	0.38			1		1	
36	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CST	0.38	4					
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CST	0.38	3		2		2	
38	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CST	0.38						
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CST	0.38						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CST	0.38			2		2	
41	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CST	0.38						
42			L038A	COMT/COT/RN/CST	0.38						
45		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38						
48		**Intra-service (of service period)**									
49	CA018	~~Assist physician or other qualified healthcare professional---directly related to physician work time (100%)~~	L038A	COMT/COT/RN/CST	0.38	6					
50	CA019	~~Assist physician or other qualified healthcare professional---directly related to physician work time (67%)~~	L038A	COMT/COT/RN/CST	0.38						
51	CA020	~~Assist physician or other qualified healthcare professional---directly related to physician work time (other%)~~						0			
52	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CST	0.38	25				30	
55			L038A	COMT/COT/RN/CST	0.38						
56		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38						
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CST	0.38						
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CST	0.38						
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CST	0.38			3		3	
63	CA025	Clean scope	L038A	COMT/COT/RN/CST	0.38						
64	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CST	0.38						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CST	0.38						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CST	0.38						
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CST	0.38						
68	CA030	~~Technologist QC's images in PACS, checking for all images, reformats, and dose page~~	L038A	COMT/COT/RN/CST	0.38						
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CST	0.38	6		0		2	
70	CA032	~~Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue~~	L038A	COMT/COT/RN/CST	0.38						
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CST	0.38						
72	CA034	~~Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)~~	L038A	COMT/COT/RN/CST	0.38						
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CST	0.38			2		2	
74	CA036	Discharge day management	L038A	COMT/COT/RN/CST	0.38	**n/a**		**n/a**		**n/a**	
75			L038A	COMT/COT/RN/CST	0.38						
78		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38						
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications	L038A	COMT/COT/RN/CST	0.38						
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CST	0.38	2		0		0	
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L038A	COMT/COT/RN/CST	0.38						
96		*Other activity: please include short clinical description here and type new*	L038A	COMT/COT/RN/CST	0.38						

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**CPT Code 92065**		**CPT Code 92065**		**CPT Code 92066**	
3		***RUC Collaboration Website***				Orthoptic and/or pleoptic training, with continuing medical direction and evaluation		Orthoptic training; performed by a physician or other qualified health care professional (Do not		Orthoptic training; under supervision of a physician or other qualified health care professional	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 10 Specialty: AAO, AOA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 26.63**	**$ -**	**$ 6.31**	**$ -**	**$ 18.47**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**48.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**46.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**CPT Code 92065**		**CPT Code 92065**		**CPT Code 92066**	
3		***RUC Collaboration Website***				Orthoptic and/or pleoptic training, with continuing medical direction and evaluation		Orthoptic training; performed by a physician or other qualified health care professional (Do not		Orthoptic training; under supervision of a physician or other qualified health care professional	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 10 Specialty: AAO, AOA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 26.63**	**$ -**	**$ 6.31**	**$ -**	**$ 18.47**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**48.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**46.0**	**0.0**	**10.0**	**0.0**	**42.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 0.35**	**$ -**	**$ 0.42**	**$ -**	**$ 0.42**	**$ -**
102	SG043	dressing, eye pad (Opticlude)	0.337	item		1		1		1	
103	SK057	paper, laser printing (each sheet)	0.0163	item		1		1		1	
104	SJ053	swab-pad, alcohol	0.0333	item				2		2	
105											
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 8.04**	**$ -**	**$ 2.09**	**$ -**	**$ 2.09**	**$ -**
112	EQ232	stereo trainer (wheatstone)	550	Default	0.001775198	46		0		0	
113	EQ236	telebinocular, ophthalmic	1014.33	Default	0.003273884	46		38		38	
114	EQ049	anomaloscope, diagnostic (HMC)	6146	Default	0.016309803	46					
115	ED009	computer and VDT and software	7100	Default	0.028131593	46		0		0	
116	EQ165	lens set, trial, full diameter, w-frame	904.93	Default	0.002401437			38		38	
117	EL006	lane, screening (oph)	39874.4787	Default	0.125234158	46					
118	EF030	table, motorized (for instruments-equipment)	895	Default	0.001990833			38		38	
119	EF043	Set of 8 chairs	4447.5435	Default	0.011802564			19		19	
120											
121											
122	**NEW**	***Pro Vision Therapy Starter System Model VTSSP***	2229.95	Default	0.008835499			38		38	
123	**NEW**	***Sanet Vision Integrator display/software***	8245	Default	0.032668308			38		38	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Caregiver Behavior Management Training – Tab 11

In February 2021, the CPT Editorial Panel created two new group caregiver behavior management training codes. CPT codes 96202 and 96203 are used to report the total duration of face-to-face time spent by the physician or other qualified healthcare professional (QHP) providing the group training session.

96202 ***Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes***

The RUC reviewed the survey results from 75 psychologists, child and adolescent psychiatrists, and dieticians with the understanding that the survey respondents were asked to evaluate the group service in total and not based on an individual group participant. Also, a custom survey question was added that asked respondents to provide the average number of patients that were represented at a typical caregiver behavior management group session. The question yielded a median response of six patients. The intent was to obtain per session data on the service, that could then be divided by the average number of patients to yield the per patient data. This methodology for surveying time-based group codes has recent precedent when it was relied on for group health behavior intervention codes 96164-96165; CMS accepted the HCPAC's recommendation in CY2020 rulemaking.

The purpose of this service is to train caregivers how to structure the environment to actively provide for and reinforce desired behaviors, reduce the negative impacts of the patient's diagnosis on patient's daily life, develop highly structured technical skills to better manage specific behaviors and support the compliance with the patient's treatment and clinical plan of care. While this service is performed without the patient present, the goals and outcomes are solely for the therapeutic benefit of the identified patient. This service is a skills training process; it is not a support group or a lecture. While the interventions are evidence-based, they are not scripted. The physician or other qualified healthcare professional must rely on their expertise and ability to integrate multiple factors, while effectively capitalizing upon the group dynamics to personalize the intervention and optimize treatment outcomes.

The specialty societies noted that although the median survey respondent has not performed this service in the past 12 months, likely due to the ongoing COVID-19 public health emergency, 2/3rds of the survey respondents have performed this service in the past 5 years and the other survey respondents were instructed to only complete the survey if they were sufficiently familiar with the service.

The RUC agreed that the median per session work value of 2.60 RVUs converted to the per patient work value of 0.43 RVUs by dividing by the typical six patients would appropriately value this service. The RUC recommends 2 minutes pre-service time, 10 minutes intra-service time, 3 minutes post-service time, for 15 minutes total time for survey code 96202. These physician/QHP times were a result of converting the median group survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service and converting them to per patient times and rounding to the nearest whole number. The RUC compared the survey code to 2nd key reference code 90847 *Family psychotherapy (conjoint*

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psychotherapy) (with patient present), 50 minutes (work RVU = 2.50, intra-service time of 50 minutes, total time of 76 minutes) and noted that for a typical group size, the survey code would involve 10 more minutes of intra-service time,14 more minutes of total time. In addition, 76 percent of the respondents that selected the 2nd key reference code indicated the survey code is more intense and complex to perform. For additional reference, the RUC compared the survey code to CPT code 90839 *Psychotherapy for crisis; first 60 minutes* (work RVU = 3.13, intra-service time of 60 minutes, total time of 90 minutes) and noted that for a typical group size both services would have identical intra-service and total times, though the reference code is somewhat less intense to perform for the typical group size of 6 patients represented.

The RUC also compared the survey code to CMS code G0109 *Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes* (work RVU = 0.25, intra-service time of 6 minutes and total time of 10 minutes), another time-based group service, which was valued based on a typical group size of 5 patients and is reported per 30 minutes instead of for the first hour of the group session (as is the case for the survey code). If G0109 was performed for 5 patients for a one hour session, the total aggregate work RVU would be 2.50; however, if the group size for G0109 was 6 patients for a one hour session, as is the case for the typical survey code, the total aggregate work RVU would be 3.00 for the reference. Group caregiver behavior management training is a somewhat more intense service to perform relative to diabetes management group training. Comparison to this reference code confirms that a value of 0.43 per patient for the survey code would not overvalue the typical physician or other QHP work. In addition, the RUC noted that unlike the reference code, which is reported in multiple units for the same patient, the survey code is structured as a base code; therefore, all the pre-service and post-service work for the entire session are included only in the base code. Also, although the median number of patients represented in a group is six, it is not uncommon for two parents/caregivers to attend a group session for the same patient for caregiver behavior management training. All else held equal, larger group sizes are somewhat more intense to lead. **The RUC recommends a work RVU of 0.43 for CPT code 96202.** The RUC noted that this recommendation is based on a median group size of six.

96203 ***Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)***
The RUC reviewed the survey results from 75 psychologists, child and adolescent psychiatrists, and dieticians with the understanding that the survey respondents were asked to evaluate the group service in total and not based on an individual group participant. Also, a custom survey question was added that asked respondents to provide the average number of patients that were represented at a typical caregiver behavior management group session. The question yielded a median response of six patients. The intent was to obtain per session data on the service, that could then be divided by the average number of patients to yield the per patient data. This methodology for surveying time-based group codes has recent precedent when it was relied on for group health behavior intervention codes 96164-96165; CMS accepted the HCPAC's recommendation in CY2020 rulemaking.

The specialty societies noted that although the median survey respondent has not performed this service in the past 12 months, likely due to the ongoing COVID-19 public health emergency, 2/3rds of the survey respondents have performed this service in the past 5 years and the other survey respondents were instructed to only complete the survey if they were at least sufficiently familiar with the service.

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The RUC agreed that the median per session work value of 0.73 RVUs converted to the per patient work value of 0.12 work RVUs by dividing by the typical six patients would appropriately value this service. The RUC recommends 3 minutes of intra-service and total time for this group-based add-on service. These physician/QHP times were a result of converting the median group survey times of 15 minutes of intra-service time and converting it to per patient times and rounding to the nearest whole number. To justify a work value of 0.12 per patient (or 0.73 for the typical group), the RUC compared the survey code to CPT code 90840 *Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 1.50, intra-service time of 30 minutes) and noted that, relative to a typical group session for the survey code reported for the same length of 30 minutes, the reference code is assigned a higher work value of 1.50 versus 1.46 for two units of the add-on survey code for 6 patients. The RUC also compared the survey code to another time-based group code 96165 *Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.10, intra-service time of 10 minutes). CPT code 96165 was valued assuming a larger group size of 7 patients. Using both services assumed typical group sizes, the survey code would represent a total aggregate work value of 0.73 compared to 0.70 for the reference code. As the survey code is slightly more intense to perform, in part because the actual number of people in the room is often higher due to the two parents commonly representing a single patient for the survey code, assigning a slightly higher value to the survey code is warranted. **The RUC recommends a work RVU of 0.12 for CPT code 96203.** The RUC noted that this recommendation is based on a median group size of 6.

Relativity Assessment Workgroup Flag
The RUC recommends that the Relativity Assessment Workgroup review these services in three years (October 2024) to review whether assumption of a median group size of 6 patients remains appropriate.

Practice Expense
The Practice Expense (PE) Subcommittee agreed to recommend a new direct supply input for a binder with dividers and noted that it is typical to provide the parent(s)/caregiver(s) with a 3-ring binder at the first session to store materials throughout the duration of the 8 sessions and there is no existing supply item that appropriately captures this resource. The PE Subcommittee also confirmed that for SK114 *tissues (Kleenex)* the number of assigned tissues is appropriate (2 tissues per patient per session (2/144 of a box)). **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Behavior Management Services** Behavior modification is the process of changing patterns of human behavior over the long-term using various motivational techniques, mainly consequences and rewards. More simply, behavior modification is the method of changing the way a person reacts either physically or mentally to a given stimulus.				

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Behavior modification treatment is based on the values of operant conditioning. The ultimate goal is to exchange objectionable, problematic, or disagreeable behaviors with more positive, desirable behaviors through the use of evidence-based techniques and methods.

The purpose of the group-based behavioral management/modification training services is to teach the parent(s)/caregiver(s) interventions that they can independently use to effectively manage the identified patient's illness(s)/disease(s). Codes 96202, 96203 are used to report the total duration of face-to-face time spent by the physician or other qualified health care professional providing group-based parent/caregiver behavioral management/modification training services. This service involves behavioral treatment training provided to a multiple-family group of parent(s)/caregiver(s), without the patient present. These services emphasize active engagement and involvement of the parent(s)/caregiver(s) in the treatment of a patient with a mental or physical health diagnosis. These services do not represent preventive medicine counseling and risk factor reduction interventions.

During these sessions, the parent(s)/caregiver(s) are trained, using verbal instruction, video and live demonstrations, and feedback from physician or other qualified health care professional or other parents in group sessions, to use skills and strategies to address behaviors impacting the patient's mental or physical health diagnosis. These skills and strategies help to support compliance with the identified patient's treatment and the clinical plan of care.

For counseling and education provided by a physician or other qualified health care professional to an individual and/or family, see the appropriate evaluation and management codes including office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), hospital *inpatient and observation* care *services* (99221, 99222, 99223, 99231, 99232, 99233), new or established patient office or other outpatient consultations (~~*99241,*~~ 99242, 99243, 99244, 99245), inpatient *or observation* consultations (~~*99251,*~~ 99252, 99253, 99254, 99255), emergency department services (99281, 99282, 99283, 99284, 99285), nursing facility services (99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316~~*, 99318*~~), ~~*domiciliary, rest home, or custodial care services (99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337),*~~ home *and residence* services (99341, 99342, ~~*99343,*~~ 99344, 99345, 99347, 99348, 99349, 99350), and counseling risk factor reduction and behavior change intervention (99401-99429). See also **Instructions for Use of the CPT Codebook** for definition of reporting qualifications.

Counseling risk factor reduction and behavior change intervention codes (99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412) are included and may not be separately reported on the same day as parent/caregiver training services codes 96202, 96203 by the same provider.

Medical nutrition therapy codes 97802, 97803, 97804, provided to the identified patient may be reported on the same date of service as parent/caregiver training service.

(For health behavior assessment and intervention that is not part of a standardized curriculum, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)

(For educational services that use a standardized curriculum provided to patients with an established illness/disease, see 98960, 98961, 98962)

(For education provided as genetic counseling services, use 96040. For education to a group regarding genetic risks, see 98961, 98962)

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●96202	E1	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes (Do not report 96202 for services to the patient and the parent[s]/caregiver[s] during the same session) (Do not report 96202 for less than 31 minutes of service)	XXX	0.43
✚●96203	E2	each additional 15 minutes (List separately in addition to code for primary service) (Use 96203 in conjunction with 96202) (Do not report 96202, 96203 in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T) (For counseling and/or risk factor reduction intervention provided by a physician or other qualified health care professional to patient[s] without symptoms or established disease, see 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412) (For educational services rendered to patients in a group setting [eg prenatal, obesity, or diabetic instructions], use 99078)	ZZZ	0.12

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96202 Tracking Number E1 Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.43**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.43**

CPT Descriptor: Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Vignette #1 - Used by APA & AACAP:
A 7-year-old male patient presents with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder. The patient's symptoms of inattention, hyperactivity and impulsiveness results in difficulties in social and psychological functioning. The patient's parent(s)/caregiver(s) is referred for group-based behavior management/modification training to learn strategies and techniques to improve monitoring and management of patient's behaviors, facilitate positive behavior changes, improved parent-child interactions, and improve overall symptom management and functioning.

Vignette #2 - Used by AND:
Parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity, and a family history of Type 2 diabetes are referred for group-based behavior management/modification training.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 16%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient records, including those from the patient's physician and other team members, and results of any prior diagnostic, evaluation and/or assessment services. Review findings from assessment tools and how they relate to the identified patient's treatment goals. Review and prepare materials to be presented during group behavior management/modification training session.

Description of Intra-Service Work: Initiate or continue the multiple-family group–based session of behavior training intervention for parent(s)/caregiver(s), training them on behavioral strategies and interventions that they can use independently, outside of treatment, and developing new skills to help improve functioning and better manage/reduce the identified patient's challenging behaviors that result from or impact the identified patient's diagnosis. Parent(s)/caregiver(s) are taught to engage via verbal instruction (didactic discussion and Socratic questioning), video, and live demonstrations, role-playing, and feedback sessions to learn how to: set realistic and age-appropriate expectations for the identified patient's behavior; reinforce positive/healthy behaviors to improve social and psychological functioning and physical health; and reduce or modify negative behaviors that are impairing function and treatment progress. Complete assessment of the identified patient's progress towards treatment goals.

Description of Post-Service Work: Documentation in the identified patient's medical record includes description of the parent(s)/caregiver(s) status and report of successes or challenges experienced with the patient, an overview of topics/skills (e.g. behavioral strategies, techniques and interventions) covered in the session, results of assessment tools completed by the parent(s)/caregiver(s), and progress toward and/or modification of treatment goals based on patient and/or

parent(s)/caregiver(s) progress or other confounding factors that arise. When applicable, coordinate with and provide feedback to the identified patient's referring provider or interdisciplinary team members. Facilitate follow-up care with identified patient and parent(s)/caregiver(s).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD					
Specialty Society(ies):	American Psychological Association, Academy of Nutrition and Dietetics (AND), American Academy of Child and Adolescent Psychiatry (AACAP)					
CPT Code:	96202					
Sample Size:	10906	**Resp N:**	75			
Description of Sample:	Random Sample of Applicable Subsets					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	8.75	50.00
Survey RVW:		1.00	2.40	**2.60**	3.00	75.00
Pre-Service Evaluation Time:				**30.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		1.00	57.50	**60.00**	90.00	720.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	96202	**Recommended Physician Work RVU: 0.43**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**3.00**	**0.00**	**3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90846	XXX	2.40	**RUC Time**

CPT Descriptor Family psychotherapy (without the patient present), 50 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90847	XXX	2.50	**RUC Time**

CPT Descriptor Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36455	XXX	2.43	**RUC Time**	49

CPT Descriptor 1 Exchange transfusion, blood; other than newborn

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Other Reference CPT Code	Global	Work RVU	Time Source
90839	XXX	3.13	**RUC Time**

CPT Descriptor Psychotherapy for crisis; first 60 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 57 **% of respondents:** 76.0 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 9.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 96202	Top Key Reference CPT Code: 90846	2nd Key Reference CPT Code: **90847**
Median Pre-Service Time	2.00	5.00	5.00
Median Intra-Service Time	10.00	50.00	50.00
Median Immediate Post-service Time	3.00	10.00	21.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**65.00**	**76.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	20%	55%	19%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	21%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	27%	70%
Physical effort required	2%	45%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	41%	53%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	17%	53%	24%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	73%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	44%	52%
Physical effort required	6%	32%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	40%	53%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Caregiver Behavioral Management/Modification Training is a highly specialized service that requires the clinical expertise of a physician or qualified health care professional (QHP) to train parent(s)/caregiver(s) how to utilize behavioral interventions, strategies and techniques to address and effectively manage behavioral problems impacting an identified patient's mental and/or physical health diagnosis. The service is offered in cases where

the provider believes psychosocial intervention (typically and most effectively provided through parent/caregiver behavioral modification/management training) is needed for the benefit of the patient to help increase effectiveness and therapeutic benefit for the patient's condition.

While this service may seem similar to existing Psychotherapy or Health Behavior Assessment and Intervention (HBAI) services, parent/caregiver behavioral management/modification training services are unique for many reasons. Primarily, the surveyed codes represent a service that is provided to parent(s)/caregiver(s) from multiple families who meet for a series of group-based sessions, conducted by a physician/QHP. While the identified patients are not present during the service, the behavioral management/modification training the parent(s)/caregiver(s) receive is solely for the benefit of the patient. The emphasis is placed on helping parent(s)/caregiver(s) develop highly structured technical skills to deal with specific problem behaviors exhibited by the identified patients.

Behavioral management/modification training is also unique in that it is not a diagnosis-specific service. Psychotherapy services are intended to be used for patients who present with a primary mental health diagnosis, while Health Behavior Assessment and Intervention (HBAI) services are intended for patients who present with a primary physical health diagnosis. The surveyed codes are typically provided to a cohort of parent(s)/caregiver(s) from multiple families over a series of eight (8) to twelve (12) closed group sessions. The participants represent identified patients that share the same or similar diagnosis.

Using our vignettes as an example, a parent/caregiver of a patient diagnosed with ADHD attends group-based behavioral management/modification training with parent(s)/caregiver(s) from multiple other families, who represent patients who have also been diagnosed with ADHD. They would not be placed in a multi-family group dedicated to addressing behavioral management/modification training for pediatric patients with obesity.

That being said, while the two (2) vignettes used in our survey process both focused on pediatric patients, a large body of scientific literature exists which describes the efficacy and effectiveness of behavioral modification and management training for caregivers of patients across the lifespan. Caregiver training for patients with dementia for example, focuses on specific behaviors the patient exhibits, and involves approaches such as modifying patient and/or caregiver cognitions, behaviors, or environments, or strategies for reducing a patient's increased vulnerability to their environment.

A new base/add-on code pair was developed to reflect the physician/QHP work involved in providing multiple-family group-based services to parent(s)/caregiver(s) (without the patient present) for which there was no existing CPT code available to capture this provision of clinical service. The CPT Editorial Panel approved 96202; *Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes* and 96203; *Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes,* at their February 2021 meeting. The codes were then surveyed by the American Psychological Association (APA), Academy of Nutrition and Dietetics (AND), and American Academy of Child and Adolescent Psychiatry (AACAP) for the April 2021 RUC meeting.

Survey Process

APA, AND, and AACAP sought the approval of the RUC's Research Subcommittee prior to fielding their surveys. The subcommittee granted approval for modification of the survey tools, including the following items:

- Providing thorough review and feedback on appropriate codes to include in our Reference Service List. All codes recommended for deletion from our initial draft of the RSLs were removed and all codes recommended for addition were added to our final versions.
- Based on the subcommittee's recommendation, we conducted the survey with two (2) separate RSLs:
    - One dedicated for use with the base code (96202) which has an XXX global period, and
    - A second dedicated for use with the add-on code (96203) which has an ZZZ global period.

- Approval of our request to utilize a secondary vignette which described the service provided to parent(s)/caregiver(s) of a pediatric patient with obesity. This vignette was only approved for use by survey respondents from AND.
- Combining the XXX – Therapy survey tool with the standard ZZZ survey template and the time-based code template to survey
- Replacing the term "physician" with "physician/qualified health care professional" to address all provider types being surveyed.
- Minor language changes throughout the survey to ask the respondents to base their time and RVU estimates on the entire group session rather than calculating them on a per patient basis.
- Adding two (2) custom questions to the survey tool:
    - The first custom question asked survey participants to indicate the total amount of time they spend performing the entire service from start to finish (including the base code and all units of the add-on code) to allow capturing the total time and work involved in each group-based service.
    - The second custom question asked survey participants to indicate the typical number of identified patients represented by their parent(s)/caregiver(s) during a typical multi-family group behavioral management/modification training group session.

All three (3) specialty societies sent surveys to a random sample of applicable subsets within their membership base. The combined sample size for the survey was 10,906. APA's sample included 1,262 members randomly selected from Division 37 – Society for Child and Family Policy and Practice, Division 53 – Society of Clinical Child and Adolescent Psychology and Division 54 – Society for Pediatric Psychology. AND's overall sample size included 8,600 members, representing a random sampling of members from 11 Dietetic Practice Groups, representing individuals providing clinical services to patients of all ages and physical health diagnoses included in the CPT Code Change Application, including pediatric patients with obesity, and eating disorders. AACAP's survey sample combined a random sample the general membership and members of the Collaborative and Integrated Care, Family, and Systems of Care Committees with a sample size of 1,044 people.

Analysis and Recommendations from the Expert Panel – 96202

An expert panel was convened with the RUC and HCPAC advisors and alternate advisors from all three surveying specialty societies, as well as practitioners from academic, and hospital-based practices, who are currently offering these services in adult and pediatric patient populations. The expert panel reviewed survey data and developed the recommendations.

When combined, 84% (63/75) of our survey respondents found the vignettes to be typical; however, as previously stated, the Research Subcommittee approved the use of two (2) vignettes during our survey process. For survey respondents from APA and AACAP, 88% (53/60) found the following vignette, which describes a patient diagnosed with a mental health condition, to be typical: A 7-year-old male patient presents with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder. The patient's symptoms of inattention, hyperactivity and impulsiveness results in difficulties in social and psychological functioning. The patient's parent(s)/caregiver(s) is referred for group-based behavior management/modification training to learn strategies and techniques to improve monitoring and management of patient's behaviors, facilitate positive behavior changes, improved parent-child interactions, and improve overall symptom management and functioning.

For survey respondents from AND, 67% (10/15) found the following vignette, which describes a patient with a physical health diagnosis, to be typical: Parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity, and a family history of Type 2 diabetes are referred for group-based behavior management/modification training.

Of the 75 completed surveys, CPT code 90846; *Family psychotherapy (without the patient present), 50 minutes*, was selected as the key reference service by 76% (57/75) of respondents. Further, of the remaining 23 respondents, 39% selected CPT code 90847; *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* as their key reference service.

Time Recommendations

Based on review of the survey results, it is clear that the survey respondents saw an analogous relationship between the surveyed codes and existing Psychotherapy and Health Behavior Assessment and Intervention

(HBAI) services. The median survey results regarding time are 30 minutes pre-service, 60 minutes intra-service, and 30 minutes post-service. The expert panel felt that the survey median intra-service time of 60 minutes, was perfectly valued, likely because it is clearly stated in the code descriptor. However, they also believed that the median pre-service and post-service times may have been slightly overvalued.

The expert panel determined that this service should be consistent with pre-service and post-service times for similar existing services. Detailed in the table below are the pre-, intra-, post-, and total times for existing family and group-based services, some of which have been calculated to show relativity and consistency:

CPT® Code	Descriptor	Pre-Time	Intra-Time	Post-Time	Total Time
90846	*Family psychotherapy (without patient present), 50 minutes*	5 x 1.2 = **6**	50 x 1.2 = **60**	10 x1.2 = **12**	65 x1.2 = **78**
96167	*Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes*	5 x 2 = **10**	30 x 2 = **60**	10 x 2 = **20**	45 x 2 = **90**
96202	***Multiple-family group behavior modification / management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes***	1.67(6*) = **10**	10(6*) = **60**	3.33(6*) = **20**	15(6*) = **90**
96170	*Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes*	5 x 2 = **10**	30 x 2 = **60**	10 x 2 = **20**	45 x 2 = **90**
90847	*Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes*	5 x 1.2 = **6**	50 x 1.2 = **60**	21 x 1.2 = **25**	76 x 1.2 = **91**
96164	*Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes*	2(7*) = 14 x1.72= **24**	5(7*) = 35 x1.72= **60**	2(7*) = 14 x1.72 = **24**	9(7*) = 63 x1.72 = **108**
90853	Group psychotherapy (other than of a multiple-family group)	2(5*) = **10**	14(5*) = **70**	8(5*) = **40**	24(5*) = **120**

*To illustrate relativity, service time has been calculated to show each service with 60 minutes of intra time. *Additionally, for group-based services, the per patient time values have been multiplied by the RUC-determined typical number of patients in the group [96164 (7), 90853 (5)] to show time for the entire group.*

<u>*Response to reviewer comments*</u>: One reviewer asked if it was typical to review each identified patient's medical record prior to every session, or was the physician/QHP just reviewing the general tenor of the material that was to be covered in the upcoming session? The expert panel appreciates the reviewer comments and we have revised our pre- and post-service descriptors to provide greater detail on the activities performed by the physician/QHP prior to and following each session.

Our expert panel agreed that, based on relativity to existing services, and taking into account that our survey respondents indicated that there are typically six (6) patients represented in a group of parent(s)/caregiver(s) participating in behavior modification/management training, there is sufficient evidence to support our recommended times for this service, to allow the physician/QHP enough pre-service time to review each identified patient's medical record and review/prepare the materials to be presented for each session, as well as post-service time to complete coordination activities (when applicable) and complete session-specific documentation in each identified patient's record. **Therefore, the expert panel recommends 10 minutes pre-, 60 minutes intra-, and 20 minutes post-service times for a total of 90 minutes for the entire group, or 2 minutes pre-, 10 minutes intra-, and 3 minutes post-service time for a total time of 15 minutes per identified patient represented by their parent(s)/caregiver(s) during behavioral management / modification training services.**

RVU Recommendations

The expert panel reviewed the RVW survey data and conducted several searches of the RUC database to identify codes that were similar to the surveyed time and RVW data. The database searches resulted in identifying numerous codes for comparison, across the fee schedule, as well as the family and group-based services reviewed with our time recommendations. . An expanded version of the previous table, used to support our time

recommendations, is provided below which shows the surveyed code, valued at the survey median (2.60) and the survey 75th percentile (3.00), relative to the codes identified in our RUC database searches.

CPT Code	Descriptor	Pre-Time	Intra-Time	Post-Time	Total Time	wRVU
90792	*Psychiatric diagnostic evaluation with medical services*	**10**	**60**	**20**	**90**	**4.16**
90791	*Psychiatric diagnostic evaluation*	**10**	**60**	**20**	**90**	**3.84**
90839	*Psychotherapy for crisis; first 60 minutes*	**10**	**60**	**20**	**90**	**3.13**
96167	*Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes*	5 x2= **10**	30 x2= **60**	10 x2= **20**	45 x2= **90**	1.55 x2= **3.10**
90847 ***KRS 2***	*Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes*	5 x1.2= **6**	50 x1.2= **60**	21 x1.2= **25**	76 x1.2= **91**	2.50 x1.2= **3.00**
96170	*Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes*	5 x2= **10**	30 x2= **60**	10 x2= **20**	45 x2= **90**	1.50 x2= **3.00**
96202	*Multiple-family group behavior modification / management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes*	1.67(6) = **10**	10(6) = **60**	3.33(6) = **20**	15(6) = **90**	**3.00** *Survey 75th*
74712	*Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation*	**15**	**60**	**15**	**90**	**3.00**
95912	*Nerve conduction studies; 11-12 studies*	**15**	**60**	**15**	**90**	**3.00**
90853	*Group psychotherapy (other than of a multiple-family group)*	2(5*) = **10**	14(5*) = **70**	8(5*) = **40**	24(5*) = **120**	0.59(5*) = **2.95**
90846 ***KRS 1***	*Family psychotherapy (without the patient present), 50 minutes*	5 x 1.2 = **6**	50 x1.2= **60**	10 x1.2 = 12	65 x1.2 = **78**	2.40 x1.2= **2.88**
96202	*Multiple-family group behavior modification / management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes*	1.67(6*) = **10**	10(6*) = **60**	3.33(6*) = **20**	15(6*) = **90**	0.43(6*) = **2.60** *Survey 50th* ***Recommended Value***
96164	*Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes*	2(7*) = 14 x1.72= **24**	5(7*) = 35 x1.72= **60**	2(7*) = 14 x1.72 = **24**	9(7*) = 63 x1.72 = **108**	0.21(7*) = 1.47 x1.72= **2.53**
97804	*Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*	2(6*) = 12 x1.67= **20**	6(6*) = 36 x1.67= **60**	2(6*) = 12 x1.67= **20**	10(6*) = 60 x1.67= **100**	0.25(6*) = 1.5x1.67= **2.51**
G0109	*Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes*	2(5*) = 10 x2 = **20**	6(5*) = 30 x2= **60**	2(5*) = 10 x2 = **20**	10(5*) = 50 x2= **100**	0.25(5*) = 1.25 x2 = **2.50**

To illustrate relativity, service RVW and time has been calculated to show each service with 60 minutes of intra time.
**Additionally, for each of the codes describing group-based services, the per patient time and wRVU values have been multiplied by the RUC-determined typical number of patients in the group [90853 (5), 96164 (7), G0109(5), 97804 (6)] to show RVW and time for the entire group.*

Response to reviewer comments: The expert panel determined that the 75th percentile value of 3.00 was the most appropriate value for this service; however, based on feedback from our reviewers as well as other members of Facilitation Committee #2, we have revised our original recommendation.

The expert panel recommends code 96202 be valued at the survey median RVW of 2.60 for the entire group, or 0.43 per identified patient represented by their parent(s)/caregiver(s), for the first 60 minutes of behavioral management/modification training services.

Additional Comments

Performance Rate

The surveying specialty societies conducted a RUC survey to value the newly created base/add-on code pair 96202 and 96203 which describe Caregiver Behavior Management/Modification Training. Upon initial analysis, the survey data revealed a median performance rate of zero for both 96202 and 96203.

Of the 75 total survey responses, 57 survey respondents selected code 90846 as the Top Key Reference Service, which had a median 12-month performance rate of 15. The Second Key Reference Service, code 90847, was selected by 7 survey respondents, and had a median 12-month performance rate of 18.

In the original version of the Survey Summary Spreadsheet, we presented the survey data in aggregate as well as for those survey respondents who had and had not performed the service in the last 12 months. For the subset of respondents who had performed the service in the last 12 months, the data showed a pre-time of 25 minutes, median intra-service time of 60 minutes, and post-service time of 30 minutes with a median RVW of 2.56 and the 75th percentile value at 2.75.

Subsequent to submission of our original recommendations, the surveying specialties felt that further analysis of the performance rate data was needed. Even though there currently is no mechanism for reporting the service, we believed this service was more commonly performed than indicated in the survey data.

Presented in the updated version of our Survey Summary Spreadsheet is recalculated performance rate information for 96202, showing the data in aggregate for all 75 survey respondents, as well as for the 50 survey respondents who said they had performed the service (either in the last 12 months and/or in the last 5 years), and those 25 survey respondents who indicated they have never performed this service. Additionally, we have included a second tab in the summary spreadsheet that only includes the 12-month performance rate data. We felt presenting the data as "performed" versus "not performed" as well as the 12-month data in isolation was a more valid and useful presentation to assist the RUC in its decision-making.

For the "performed" versus "not performed" recalculated data, time data for 96202 in aggregate showed median times of 30/60/30, totaling 120 minutes. These data points were exactly the same for those who have performed the service, and for those who indicated they have never performed the service, the only difference was a median pre-time of 27 minutes, which in turn brought the total time down to 117 minutes. For the data on the estimated RVW, the median value in the aggregate data for 96202 was 2.60 and the 75th percentile was 3.00. These RVW values were exactly the same for the 50 survey respondents who indicated they have performed the service, and for those 25 respondents who said they'd never performed the service, the 25th percentile RVW at 2.60, the median at 3.00 and the 75th percentile at 3.06. In summary, the updated performance rate data reveals that there is very little variation in the data across all three (3) cohorts. This also shows that the survey conducted yielded strong, consistent data, further supporting our time and valuation recommendations for this service.

Additionally, the re-calculated data for those survey respondents who indicated that they have performed the service results in a median service performance rate of 19 for 96202. It should be noted however, that although these service performance rates may still seem low, this service is provided over 8-12 sessions. Therefore, a performance rate of 19 means the service was provided to 19 groups, totaling 152-228 sessions provided by the physician/QHP.

We had 33 respondents who indicated they had performed 96202 in the last 12 months. The top and second KRS codes were the same as the overall data, with 90846 being selected by 64% (21/33) respondents and 90847 being selected by 21% (7/33) respondents. The aggregate data was consistent with the data from the overall survey, with the median RVW at 2.56, and median surveyed times of 25/60/30.

Additionally, the 12-month performance data showed a median service performance rate of 20 for 96202. It should be noted however, that although these service performance rates may still seem low, this service is

provided over 8-12 sessions. Therefore, a performance rate of 20 means the service was provided to 20 groups, totaling 160-240 sessions provided by the physician/QHP.

Custom Question Survey Results
As noted previously under the Survey Process section of our rationale, approval was granted by the RUC Research Subcommittee, to modify question 5 on the survey instrument to request that respondents value the service based on the entire group, not the individual patient. Approval was also granted to add custom questions to ascertain the typical time spent performing the entire service and the typical number of patients represented in the group.

Custom Question 1 – Total Time/Units for XXX base survey code and ZZZ add-on survey code(s)
The first custom question asked survey participants to indicate the total amount of time they spend performing the entire service from start to finish (including the base code and all units of the add-on code) to allow capturing the total time and work involved in each group-based service.

For the typical group, how much time do you personally spend performing this entire service from start to finish (96202 and all increments of 96203)? Please answer in minutes. Please do not count pre-service time (e.g., chart review) or post-service time (e.g., documentation).

The intent of including this custom question was to determine the total time, in minutes, it takes to perform the service, as well as the typical number of add-on code units that would be reported, beyond the initial 60 minutes included in the base code, for a typical training session. The survey data collected is summarized below:

Min.	25th Percentile	Median	75th Percentile	Max.
30 minutes	60 minutes	90 minutes	90 minutes	180 minutes

Also, as seen in the table below, based on the 12-month performance rate data, the total time, in minutes, it takes to perform the service, was very consistent with the overall survey data:

Min.	25th Percentile	Median	75th Percentile	Max.
55 minutes	75 Minutes	90 minutes	90 minutes	180 minutes

Based on the responses from the survey respondents, the typical length of this service is between 60-90 minutes; therefore, it can be expected that the service will be reported with either a single unit of the 96202 for a 60 minute service, or one (1) unit of 96202, and two (2) units of the 96203 for a 90 minute service.

Custom Question 2 – Typical Number of Patients Represented in the Group
The second custom question asked survey participants to indicate the typical number of identified patients represented by their parent(s)/caregiver(s) during a typical multi-family group behavioral management/modification training group session.

What is the typical number of patients represented by their parent(s)/caregiver(s) in a typical group session for survey base code 96202 *Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes*?

The responses to this custom question regarding the typical number patients represented by their parent(s)/caregiver(s) in a typical group session, are summarized below:

Min.	25th Percentile	Median	75th Percentile	Max.
1	4	6	8	15

Also, as seen in the table below, based on the 12-month performance rate data, the typical number patients represented by their parent(s)/caregiver(s) in a typical group session, was very consistent with the overall survey data:

Min.	25th Percentile	Median	75th Percentile	Max.
1	4	6	8	19

With six (6) identified patients represented in a group of parent(s)/caregiver(s) receiving behavior modification and management training, a typical series of training sessions would include two (2) parent(s)/caregiver(s) representing each identified patient, or a total of 12 parent(s)/caregiver(s) participating in the group-based series of sessions.

Response to reviewer comments: A comment was made by one of our reviewers related to how number of RVUs generated is dependent upon the number of patients represented in the group. Another reviewer asked whether there needed to be any limits on the number of patients that can be represented in a single group. Upon further analysis, the surveying specialties found when comparing the data in aggregate to those survey respondents who indicated they had "performed" or "not performed" this service, the typical number of patients represented in the group remained the same.

Recommendations

In summary, based on strong support from our overall survey data as well as consistency with the 12-month performance rate data, **we recommend the survey median RVW of 2.60 with 10 minutes pre-, 60 minutes intra-, and 20 minutes post-time for a total time of 90 minutes for 96202 (for the entire group). When divided by the typical number of patients represented in a group (6), the per patient recommendations are 0.43 RVUs with 2 minutes pre-, 10 minutes intra-, and 3 minutes post-time for a total time of 15 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	CPT Code	Global	Work RVU	Pre-	Intra-	Post-
3.	96202	XXX	2.60	10	60	20
4.	+96203	ZZZ	0.73	0	15	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Clinical Psychology How often? Commonly

Specialty Registered Dietitian/Nutrition Professional How often? Commonly

Specialty Child & Adolescent Psychiatry How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 260000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A typical course of treatment is 8 sessions per cohort. If a physician/QHP provides 4 cohorts per year, that would be 32 sessions per year. With the survey median data showing that there are typically 6 patients represented in each of the annual 32 sessions then, if we assume that 10% of our combined survey sample (10,960) utilized the codes, then we estimate the national utilization to be 200,000 base units/year.

Specialty Clinical Psychology Frequency 75000 Percentage 28.84 %

Specialty Registered Dietitian Nutritionists Frequency 165000 Percentage 63.46 %

Specialty Child & Adolescent Psychiatry Frequency 20000 Percentage 7.69 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. When comparing utilization of existing codes, AND believes that 2019 utillization of G0109 would be similar to utilization of the new services while APA and AACAP believe currecnt utilization for 90846 would be similar. Calcualting for differences in time between the existing and surveyed codes yeild the estimated utilization in Medicare .

Specialty Clinical Psychology Frequency 25000 Percentage 25.00 %

Specialty Registered Dietitian Nutritionists Frequency 55000 Percentage 55.00 %

Specialty Child & Adolescent Psychiatry Frequency 20000 Percentage 20.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Psychiatry

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. G0109

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96203 Tracking Number E2 Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.12**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **0.12**

CPT Descriptor: Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Vignette #1 - Used by APA & AACAP:
During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 7-year-old male patient with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder, received training on monitoring and coping with the identified patient's symptoms of inattention, hyperactivity and impulsiveness, and facilitating positive behavior changes. An additional 15 minutes, beyond the first 60 minutes, was required to complete group behavior management/modification training on improving overall symptom management and functioning.
[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]

Vignette #2 - Used by AND:
During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity and a family history of Type 2 diabetes received training. An additional 15 minutes was required.
[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 12%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Continue multiple-family group–based session of behavior training intervention for parent(s)/caregiver(s), including verbal instruction (didactic discussion and Socratic questioning), video, and live demonstrations, role-playing, and feedback sessions to learn how to: set realistic and age-appropriate expectations for the identified patient's behavior; reinforce positive/healthy behaviors to improve social and psychological functioning and physical health; and reduce or modify negative behaviors that are impairing function and treatment progress.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021
Presenter(s):	Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD
Specialty Society(ies):	American Psychological Association, Academy of Nutrition and Dietetics (AND), American Academy of Child and Adolescent Psychiatry (AACAP)
CPT Code:	96203
Sample Size: 10906	**Resp N:** 75
Description of Sample:	Random Sample of Applicable Subsets

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	11.50	288.00
Survey RVW:	0.25	0.54	**0.73**	1.00	90.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	15.00	**15.00**	30.00	150.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code: 96203	**Recommended Physician Work RVU: 0.12**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**3.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96171	ZZZ	0.54	**RUC Time**

CPT Descriptor Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96168	ZZZ	0.55	**RUC Time**

CPT Descriptor Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77001	ZZZ	0.38	**RUC Time**	310,854

CPT Descriptor 1 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 55 **% of respondents:** 73.3 **%**

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 96203	Top Key Reference CPT Code: 96171	2nd Key Reference CPT Code: **96168**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	3.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**3.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	60%	32%	50%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	1%	36%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	31%	63%
Physical effort required	4%	49%	47%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	41%	50%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	1%	4%	24%	50%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	32%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	32%	64%
Physical effort required	1%	52%	47%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	49%	47%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Caregiver Behavioral Management/Modification Training is a highly specialized service that requires the clinical expertise of a physician or qualified health care professional (QHP) to train parent(s)/caregiver(s) how to utilize behavioral interventions, strategies, and techniques to address and effectively manage behavioral problems impacting an identified patient's mental and/or physical health diagnosis. The service is offered in cases where the provider believes psychosocial intervention (typically and most effectively provided through parent/caregiver behavioral modification/management training) is needed for the benefit of the patient to help increase effectiveness and therapeutic benefit for the patient's condition.

While this service may seem similar to existing Psychotherapy or Health Behavior Assessment and Intervention (HBAI) services, parent/caregiver behavioral management/modification training services are unique for many reasons. Primarily, the surveyed codes represent a service that is provided to parent(s)/caregiver(s) from multiple families who meet for a series of group-based sessions, conducted by a physician/QHP. While the identified patients are not present during the service, the behavioral management/modification training the parent(s)/caregiver(s) receive is solely for the benefit of the patient. The emphasis is placed on helping parent(s)/caregiver(s) develop highly structured technical skills to deal with specific problem behaviors exhibited by the identified patients.

Behavioral management/modification training is also unique in that it is not a diagnosis-specific service. Psychotherapy services are intended to be used for patients who present with a primary mental health diagnosis, while Health Behavior Assessment and Intervention (HBAI) services are intended for patients who present with a primary physical health diagnosis. The surveyed codes are typically provided to a cohort of parent(s)/caregiver(s) from multiple families over a series of eight (8) to twelve (12) closed group sessions. The participants represent identified patients that share the same or similar diagnosis.

Using our vignettes as an example, a parent/caregiver of a patient diagnosed with ADHD attends group-based behavioral management/modification training with parent(s)/caregiver(s) from multiple other families, who represent patients who have also been diagnosed with ADHD. They would not be placed in a multi-family group dedicated to addressing behavioral management/modification training for pediatric patients with obesity.

While the two (2) vignettes used in our survey process both focused on pediatric patients, a large body of scientific literature exists which describes the efficacy and effectiveness of behavioral modification and management training for caregivers of patients across the lifespan. Caregiver training for patients with dementia, for example, focuses on specific behaviors the patient exhibits, and involves approaches such as modifying patient and/or caregiver cognitions, behaviors, or environments, or strategies for reducing a patient's increased vulnerability to their environment.

The CPT Editorial Panel approved this new base/add code pair at their February 2021 meeting to reflect the physician/QHP work involved in providing multiple-family group-based services to parent(s)/caregiver(s) (without the patient present) for which there was no existing CPT code available to capture this provision of clinical service.

The surveyed code 96203; *Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)*, is an 15-minute add-on code to the base service, code 96202, which is reported for the first 60 minutes of behavior management/modification training. Based on feedback from those that completed the RUC survey, the survey median value for the length of a single session of this service was 90 minutes and the typical number of identified patients represented in a group was six (6); therefore, for a typical single session, we anticipate physicians/QHPs to report one unit of the base code (96202) and two units of the add-on code (96203) per patient.

Survey Process

APA, AND, and AACAP sought the approval of the RUC's Research Subcommittee prior to fielding their surveys. The subcommittee granted approval for modification of the survey tools, including the following items:

- Providing thorough review and feedback on appropriate codes to include in our Reference Service List. All codes recommended for deletion from our initial draft of the RSLs were removed and all codes recommended for addition were added to our final versions.
- Based on the subcommittee's recommendation, we conducted the survey with two (2) separate RSLs:
    - One dedicated for use with the base code (96202) which has an XXX global period, and
    - A second dedicated for use with the add-on code (96203) which has an ZZZ global period.
- Approval of our request to utilize a secondary vignette which described the service provided to parent(s)/caregiver(s) of a pediatric patient with obesity. This vignette was only approved for use by survey respondents from AND.
- Combining the XXX – Therapy survey tool with the standard ZZZ survey template and the time-based code template to survey
- Replacing the term "physician" with "physician/qualified health care professional" to address all provider types being surveyed.
- Minor language changes throughout the survey to ask the respondents to base their time and RVU estimates on the entire group session rather than calculating them on a per patient basis.
- Adding two (2) custom questions to the survey tool:
    - The first custom question asked survey participants to indicate the total amount of time they spend performing the entire service from start to finish (including the base code and all units of the add-on code) to allow capturing the total time and work involved in each group-based service.
    - The second custom question asked survey participants to indicate the typical number of identified patients represented by their parent(s)/caregiver(s) during a typical multi-family group behavioral management/modification training group session.

All three (3) specialty societies sent surveys to a random sample of applicable subsets within their membership base. The combined sample size for the survey was 10,906. APA's sample included 1,262 members randomly selected from Division 37 – Society for Child and Family Policy and Practice, Division 53 – Society of Clinical Child and Adolescent Psychology and Division 54 – Society for Pediatric Psychology. AND's overall sample size included 8,600 members, representing a random sampling of members from 11 Dietetic Practice Groups, representing individuals providing clinical services to patients of all ages and physical health diagnoses included in the CPT Code Change Application, including pediatric patients with obesity….. AACAP's survey sample combined a random sample the general membership and members of the Collaborative and Integrated Care, Family, and Systems of Care Committees with a sample size of 1,044 people.

Analysis and Recommendations from the Expert Panel – 96203

An expert panel was convened with the RUC and HCPAC advisors and alternate advisors from all three surveying specialty societies, as well as practitioners from academic, and hospital-based practices, who are currently offering these services in adult and pediatric patient populations. The expert panel reviewed survey data and developed the recommendations.

The use of two (2) vignettes was approved by the Research Subcommittee for use in the survey of these services. The first vignette, used by survey respondents from APA and AACAP, described a patient with a mental health diagnosis, and 90% (53/59) of the respondents found the following described their typical patient: During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 7-year-old male patient with Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder, received training on monitoring and coping with the identified patient's symptoms of inattention, hyperactivity and impulsiveness, and facilitating positive behavior changes. An additional 15 minutes, beyond the first 60 minutes, was required to complete group behavior management/modification training on improving overall symptom management and functioning.

The second vignette, used by survey respondents from AND, described a patient with a physical health diagnosis, and 73% (11/15) of the respondents found the following to describe their typical patient: During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity and a family history of Type 2 diabetes received training. An additional 15 minutes was required.

When combined, 86% (64/74)of our survey respondents found the vignettes to be typical; however, it should be noted that five (5) APA members commented that they did not find the vignette to be typical because they typically provide behavioral management/modification training to the parent(s)/caregiver(s) of patients with physical health diagnosis (e.g. obesity); therefore, given the option, the secondary vignette that was approved by the Research Subcommittee for use only by AND's survey respondents, would have been selected, increasing our combined approval rate to 95%.

Time Recommendations

Based on review of the survey results, our expert panel believed that the survey respondents saw an analogous relationship between the surveyed code and existing add-on codes in the family of Health Behavior Assessment and Intervention (HBAI) services. Of the 75 completed surveys, CPT code 96171; *Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes* (List separately in addition to code for primary service), was selected as the key reference service by 75% (56/75) of respondents. Of the remaining survey respondents, 74% (14/19) selected CPT code 96168; *Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) as their key reference service*. The intra-service survey median time for 96203 was 15 minutes, as is the intra-service time for each of the HBAI add-on codes.

When compared to the 12-month performance data, the intra-time estimation is very consistent with the overall survey data, yielding a median intra-time of 15 minutes.

For 96203, the expert panel recommends 15 minutes of intra-service time for the entire group, or 3 minutes intra-service time per identified patient represented by their parent(s)/caregiver(s) during behavioral management / modification training services.

RVW Recommendations

Response to reviewer comments: The expert panel determined that the 75th percentile value of 1.00 was the most appropriate value for this service; however, based on feedback from our reviewers as well as other members of Facilitation Committee #2, we have revised our original recommendation.

For 96203, the expert panel recommends the survey median RVW value of 0.73 for the entire group, or 0.12 per identified patient represented by their parent(s)/caregiver(s) during behavioral management / modification training services.

Additional Comments

Performance Rate

The surveying specialty societies conducted a RUC survey to value the newly created base/add-on code pair 96202 and 96203 which describe Caregiver Behavior Management/Modification Training. Upon initial analysis, the survey data revealed a median performance rate of zero for 96203. The median performance rate of zero for 96203.

Of the 75 total survey responses, 56 survey respondents selected code 96171 as the Top Key Reference Service, which had a median performance rate was 2. The Second Key Reference Service, code 96168, was selected by 14 survey respondents, and had a median performance rate of 10.

In the original version of the Survey Summary Spreadsheet, we presented the survey data in aggregate as well as for those survey respondents who had and had not performed the service in the last 12 months. . For the subset of respondents who had performed the service in the last 12 months, the data showed a pre-time of 25 minutes, median intra-service time of 60 minutes, and post-service time of 30 minutes with a median RVW of 2.56 and the 75th percentile value at 2.75.

Subsequent to submission of our original recommendations, the surveying specialties felt that further analysis of the performance rate data was needed. Even though there currently is no mechanism for reporting the service, we believed this service was more commonly performed than indicated in the survey data.

Presented in the updated version of our Survey Summary Spreadsheet is recalculated performance rate information for 96203, showing the data in aggregate for all 75 survey respondents, as well as for the 50 survey respondents who said they had performed the service (either in the last 12 months and/or in the last 5 years), and those 25 survey respondents who indicated they have never performed this service. Additionally, we have included a second tab in the summary spreadsheet that only includes the 12-month performance rate data for 96203. We felt presenting the data as "performed" versus "not performed" as well as the 12-month data in isolation was a more valid and useful presentation to assist the RUC in its decision-making. When compared to the data in aggregate, the updated performance rate data reveals significant consistency across all three (3) data sets, with very little variation in the estimated times or RVW values.

For the "performed" versus "not performed" recalculated data, the survey data for 96203 for all 75 survey respondents showed the median intra-time was 15 minutes, with the median RVW was 0.73, and the 75th percentile at 1.00. The median intra-time was the same for the 50 survey respondents who indicated they had performed the service, with the median RVU valued at 0,70. For those 25 respondents who indicated they had never performed the service, the 25th percentile intra-time was 15 minutes, and the median was 17 minutes, and the estimated RVW was 0.75. In summary, the updated performance rate data reveals that there is very little variation in the data across all three (3) cohorts. This also shows that the survey conducted yielded strong, consistent data, further supporting our time and valuation recommendations for of this service.

Additionally, the re-calculated data for those survey respondents who indicated that they have performed the service results in a median service performance rate of 20 for 96203. It should be noted however, that although these service performance rates may still seem low, this service is provided over 8-12 sessions. Therefore, a performance rate of 20 means the service was provided to 20 groups, totaling 160-240 sessions provided by the physician/QHP.

We had 30 respondents who indicated they had performed 96202 in the last 12 months. The top and second KRS codes were the same as the overall data, with 96171 being selected by 67% (20/30) respondents and 96168 being selected by 27% (8/30) respondents. The aggregate 12-month performance data was consistent with the data from the overall survey, with the median RVW at 0.70, and surveyed median intra-time at 15 minutes.

Additionally, the 12-month performance data showed a median service performance rate of 24 for 96203. It should be noted however, that although these service performance rates may still seem low, this service is provided over 8-12 sessions. Therefore, a performance rate of 24 means the service was provided to 24 groups, totaling 192-288 sessions provided by the physician/QHP.

Custom Question Survey Results

As noted previously under the Survey Process section of our rationale, approval was granted by the RUC Research Subcommittee, to modify question 5 on the survey instrument to request that respondents value the service based on the entire group, not the individual patient. Approval was also granted to add custom questions to ascertain the typical time spent performing the entire service and the typical number of patients represented in the group.

Custom Question – Total Time/Units for XXX base survey code and ZZZ add-on survey code(s)

The first custom question asked survey participants to indicate the total amount of time they spend performing the entire service from start to finish (including the base code and all units of the add-on code) to allow capturing the total time and work involved in each group-based service.

For the typical group, how much time do you personally spend performing this entire service from start to finish (96202 and all increments of 96203)? Please answer in minutes. Please do not count pre-service time (e.g., chart review) or post-service time (e.g., documentation).

The intent of including this custom question was to determine the total time, in minutes, it takes to perform the service, as well as the typical number of add-on code units that would be reported, beyond the initial 60 minutes included in the base code, for a typical training session. The survey data collected is summarized below:

Min.	25th Percentile	Median	75th Percentile	Max.

30	60	90	90	180

The consistency in the data provided by our survey respondents allows us to better understand and anticipate how this service will be provided and reported by physicians/QHPs upon implementation.

Custom Question 2 – Typical Number of Patients Represented in the Group
The second custom question asked survey participants to indicate the typical number of identified patients represented by their parent(s)/caregiver(s) during a typical multi-family group behavioral management/modification training group session.

What is the typical number of patients represented by their parent(s)/caregiver(s) in a typical group session for survey base code 96202 *Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes*?

The responses to this custom question regarding the typical number patients represented by their parent(s)/caregiver(s) in a typical group session, are summarized below:

Min.	25th Percentile	Median	75th Percentile	Max.
1	4	6	8	15

Also, as seen in the table below, based on the 12-month performance rate data, the typical number patients represented by their parent(s)/caregiver(s) in a typical group session, was very consistent with the overall survey data:

Min.	25th Percentile	Median	75th Percentile	Max.
1	4	6	8	19

Recommendations
In summary, based on our overall survey results, as well as consistency with the 12-month performance data, **we recommend the survey median RVW of 0.73 with 0 minutes pre-, 15 minutes intra-, and 0 minutes post-time for a total time of 15 minutes for 96203 (for the entire group), or 0.12 RVUs and 3 minutes of intra-time on a per patient basis.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global	Work RVU	Pre-	Intra-	Post-
4.	96202	XXX	2.60	10	60	20
5.	+96203 ZZZ	0.73	0	15	0	

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Clinical Psychology How often? Commonly

Specialty Registered Dietitian/Nutrition Professional How often? Commonly

Specialty Child & Adolescent Psychiatry How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 400,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated that the national utilization for the base code, 96202, to be 200,000 base units/year and considering our survey respondents indicated that the typical total time per session would be 90 minutes, we doubled that estimate for the add-on code units.

Specialty Clinical Psychology Frequency 150000 Percentage 37.50 %

Specialty Registered Dietitian Nutritionists Frequency 330000 Percentage 82.50 %

Specialty Child & Adolescent Psychiatry Frequency 40000 Percentage 10.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated that the Medicare utilization for the base code, 96202, to be 100,000 base units/year and considering using the same methodology as we did for the national estimates, we doubled that esitmate to meet the survey respondent's indiciation that the typical total time per session would be 90 minutes.

Specialty Clinical Psychology Frequency 50000 Percentage 25.00 %

Specialty Registered Dietitian Nutritionists Frequency 110000 Percentage 55.00 %

Specialty Child & Adolescent Psychiatry Frequency 40000 Percentage 20.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Psychiatry

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. G0109

SS Rec Summary

ISSUE: Caregiver Behavior Management Training

TAB: 11

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	90846	XXX	Family psychotherapy (without the patient present), 50 minutes	57	0.041	0.037			2.40			65	5					50			10
2nd REF	90847	XXX	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	7	0.038	0.033			2.50			76	5					50			21
SVY	96202	XXX	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes	75	0.021	0.022	1.00	2.40	2.60	3.00	75.00	120	30			1	58	60	90	720	30
SVY	96202	XXX	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes	75	0.021	0.022	0.17	0.40	0.43	0.50	12.50	20	5			0.17	10	10	15	120	5
REC	96202		Entire Group		0.032	0.029			2.60			90	10					60			20
REC	96202		Per Patient (Entire Group values divided by 6)		0.032	0.029			0.43			15	2					10			3

96203

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	96171	ZZZ	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	55	0.036	0.036			0.54			15						15			
2nd REF	96168	ZZZ	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	15	0.037	0.037			0.55			15						15			
SVY	96203	ZZZ	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)	75	0.048	0.048	0.25	0.54	0.73	1.00	90.00	15				0	15	15	30	150	
SVY	96203	ZZZ	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)	75	0.048	0.048	0.04	0.09	0.12	0.17	15.00	2.5				0	3	3	5	25	
REC	96203	ZZZ	Entire Group		0.049	0.049			0.73			15						15			
REC	96203	ZZZ	Per Patient (Entire Group values divided by 6)		0.048	0.040			0.12			3						3			

FACILITY DIRECT PE INPUTS

CPT CODE(S): 96202-96203

SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)

PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
96202	Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes	XXX
96203	Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
96202	A 7-year-old male patient presents with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder. The patient's symptoms of inattention, hyperactivity and impulsiveness results in difficulties in social and psychological functioning. The patient's parent(s)/caregiver(s) is referred for group-based behavior management/modification training to learn strategies and techniques to improve monitoring and management of patient's behaviors, facilitate positive behavior changes, improved parent-child interactions, and improve overall symptom management and functioning.
96202	Parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity, and a family history of Type 2 diabetes are referred for group-based behavior management/modification training.
96203	During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 7-year-old male patient with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder, received training on monitoring and coping with the identified patient's symptoms of inattention, hyperactivity and impulsiveness, and facilitating positive behavior changes. An additional 15 minutes, beyond the first 60 minutes, was required to complete group behavior management/modification training on improving overall symptom management and functioning. [Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]
96203	During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity and a family history of Type 2 diabetes received training. An additional 15 minutes was required. [Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

FACILITY DIRECT PE INPUTS

CPT CODE(S): 96202-96203

SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)

PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

A consensus panel of experts from the American Psychological Association (APA), Academy of Nutrition and Dietetics (AND), and the American Academy of Child and Adolescent Psychiatry (AACAP) met by video conference to develop the practice expense input recommendations The panel was comprised of the advisors and alternate advisors from the participating societies utilizing additional input obtained via email from experts from each of the societies providing the services in both facility and non-facility settings across the country.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Reference for 96202: 90846; *Family psychotherapy (without the patient present), 50 minutes* which was the key reference service selected by 76% of our survey respondents.
Reference for 96203: 96171: *Health behavior intervention, family (without the patient present); face-to-face; each additional 15 minutes,* which was the key reference service selected by 73% of our survey respondents.

We also looked at PE for similar services deemed appropriate reference codes:
96164: Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165: Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes
96167: Health behavior intervention, family (with patient present), face-to-face, initial 30 minutes
96168; Health behavior intervention, family (with patient present), face-to face, each additional 15 minutes
96170: Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96047: Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849: Multiple-family group psychotherapy
90853: Group psychotherapy (other than of a multiple-family group)
G0109: Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
97804: Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

3. Is this code(s) typically reported with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence*

guidelines) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

No clinical staff work. Standard pre-service PE activities such as greeting parent(s)/caregiver(s) performed by administrative staff.

   c. Post-service period:

N/A

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No X
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

    N/A

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

    N/A

16. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

    N/A

17. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

    N/A

18. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

19. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

    N/A

FACILITY DIRECT PE INPUTS

CPT CODE(S): 96202-96203

SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)

PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S):96202-96203
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
96202	Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes	XXX
96203	Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
96202	A 7-year-old male patient presents with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder. The patient's symptoms of inattention, hyperactivity and impulsiveness results in difficulties in social and psychological functioning. The patient's parent(s)/caregiver(s) is referred for group-based behavior management/modification training to learn strategies and techniques to improve monitoring and management of patient's behaviors, facilitate positive behavior changes, improved parent-child interactions, and improve overall symptom management and functioning.
96202	Parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity, and a family history of Type 2 diabetes are referred for group-based behavior management/modification training.
96203	During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 7-year-old male patient with attention-deficit/hyperactivity disorder and Oppositional Defiant Disorder, received training on monitoring and coping with the identified patient's symptoms of inattention, hyperactivity and impulsiveness, and facilitating positive behavior changes. An additional 15 minutes, beyond the first 60 minutes, was required to complete group behavior management/modification training on improving overall symptom management and functioning. [Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]
96203	During the group-based behavior management/modification training, the parent(s)/caregiver(s) of a 10-year-old male patient with obesity, limited variety of food intake, limited physical activity and a family history of Type 2 diabetes received training. An additional 15 minutes was required. [Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 96202.]

NONFACILITY DIRECT PE INPUTS

CPT CODE(S):96202-96203
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A consensus panel of experts from the American Psychological Association (APA), Academy of Nutrition and Dietetics (AND), and the American Academy of Child and Adolescent Psychiatry (AACAP) met by video conference to develop the practice expense input recommendations The panel was comprised of the advisors and alternate advisors from the participating societies utilizing additional input obtained via email from experts from each of the societies providing the services in both facility and non-facility settings across the country.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference for 96202: 90846; *Family psychotherapy (without the patient present), 50 minutes* which was the key reference service selected by 76% of our survey respondents.
   Reference for 96203: 96171: *Health behavior intervention, family (without the patient present); face-to-face; each additional 15 minutes,* which was the key reference service selected by 73% of our survey respondents.

   We also looked at PE for similar services deemed appropriate reference codes:
   96164: Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
   96165: Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes
   96167: Health behavior intervention, family (with patient present), face-to-face, initial 30 minutes
   96168; Health behavior intervention, family (with patient present), face-to face, each additional 15 minutes
   96170: Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
   96047: Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
   90849: Multiple-family group psychotherapy
   90853: Group psychotherapy (other than of a multiple-family group)
   G0109: Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
   97804: Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No. New Codes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   New codes.

CPT CODE(S):96202-96203
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

New codes. No vital signs are obtained for this service.

9. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

N/A

    b. Service period (includes pre, intra and post):

No clinical staff work. Standard pre-service PE activities such as greeting parent(s)/caregiver(s) performed by administrative staff.

    c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

NONFACILITY DIRECT PE INPUTS

CPT CODE(S):96202-96203
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

See attached paid invoice for the 2 inch 3 ring binder and set of 8 divider tabs purchased from an office supply vendor under a corporate office supply account.

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

CPT CODE(S):96202-96203
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
PRESENTER(S): Stephen Gillaspy, PhD, Sherry Barron-Seabrook, MD, Kai-ping Wang, MD, Karen Smith, MS, MBA, RD, LD, FAND, Eileen Myers, MPH, LDN, RDN, FAND, Scott Sperling, PsyD, Melissa Santos, PhD, Richard E.A. Loren, PhD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Line 115: EF043 Set of 8 Chairs
In the non-facility setting, this service is typically performed in the practice's waiting room during non-office hours. Additional seating is needed for the entire duration of the service beyond what is typically available in the waiting room to accommodate the typical group size of 13 individuals (1 physician or QHP and 6 patients represented by 2 parents/caregivers each). In developing our recommendations, our expert panel felt it was typical to have 5 chairs available in the waiting room, hence we are requesting 8 additional chairs to accommodate the typical group size. In the facility setting, waiting rooms are typically larger or classroom/conference room space is typically available within the facility for use for this service. The total intra-service time of 60 minutes for the base code was divided by the typical group size (6) to yield 10 minutes. Similarly, the total intra-service time of 15 minutes for the add-on code was divided by the typical group size (6) to yield 2.5 minutes. This methodology is consistent with methodology used for the group reference service codes.

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

SK114 tissue (Kleenex): 2 tissues per patient represented per session (2/144 of a box).
SK005 assessment monitoring instruments: An important feature of this service is self-reported monitoring data used to assess parent(s)/caregiver(s) effectiveness at facilitating desired behavior changes to reach care plan goals. Standardized tools with simple scoring guidelines are used to support self-assessment by the parents/caregivers and support decision-making by the physician/QHP on the design of each service session. An instrument is used at the beginning and end of each session.
SK057: paper, laser printing: In a typical session, parent(s)/caregiver(s) are provided with printed materials, generally reproduced by the practice, on the behavior management/training techniques introduced and practiced during the session as a reference for use when applying/practicing the techniques with the patient. Written homework assignments are provided along with written tools for documenting these assignments (e.g., behavior logs, journals, other tracking tools).
New Items: 2" 3-ring binder and set of 8 dividers: Per our expert panel and providers they consulted who have provided this service, it is typical to provide the parent(s)/caregiver(s) with a 3-ring binder at the first session to store materials throughout the duration of sessions. With the typical service consisting of 8 sessions, dividers are used to separate content for each session. The binder with dividers is provided at the first session, hence we divided the total cost by 8. At the time we originally submitted our PE spreadsheet and SOR, while our expert panel felt a binder was

typical, since we did not have a paid invoice for this new supply we opted to use SK043 file labels-folder as an appropriate substitute from the supplies list. The question from a PE reviewer regarding the absence of a file folder prompted us to revisit the supplies and recommend the binder with dividers to represent the supplies truly typical for this service.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	K	L	M	N	Q	R
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 90846**		**CPT Code 96202**		**CPT Code 96171**		**CPT Code 96203**	
3		***RUC Collaboration Website***				Family psychotherapy (without the patient present), 50 minutes		behavior modification/management training for guardians/caregivers of a patient with a		Health behavior intervention, family (without the patient present), face-to-face; each additional 15		Multiple-family group behavior modification/management training for guardians/caregivers	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 11 Specialty: APA, AACAP, AND**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 0.25**	**$ -**	**$ 8.65**	**$ -**	**$ 0.04**	**$ -**	**$ 0.03**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery/procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37								
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37								
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37								
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37								
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37								
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37								
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37								
23			L037D	RN/LPN/MTA	0.37								
26		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37								
29		**End: When patient enters office/facility for surgery/procedure**											
30		**SERVICE PERIOD**											
31		**Start: When patient enters office/facility for surgery/procedure:**											
32		**Pre-Service (of service period)**											
33	CA009	~~Greet patient, provide gowning, ensure appropriate medical records are available~~	L037D	RN/LPN/MTA	0.37								
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37								
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37								
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37								
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37								
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37								
42			L037D	RN/LPN/MTA	0.37								
45		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37								
48		**Intra-service (of service period)**											
49	CA018	~~Assist physician of other qualified healthcare professional---directly related to physician work time (100%)~~	L037D	RN/LPN/MTA	0.37								
50	CA019	~~Assist physician of other qualified healthcare professional---directly related to physician work time (60%)~~	L037D	RN/LPN/MTA	0.37								
51	CA020	~~Assist physician of other qualified healthcare professional---directly related to physician work time (other%)~~	L037D	RN/LPN/MTA	0.37								
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37								
55			L037D	RN/LPN/MTA	0.37								
56		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37								
59		**Post-Service (of service period)**											
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37								
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37								
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37								
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37								
72	CA034	~~Document procedure (non-ACO) (e.g. mandated reporting, registry logs, EEG file, etc.)~~	L037D	RN/LPN/MTA	0.37								
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37								
75			L037D	RN/LPN/MTA	0.37								
78		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37								
81		**End: Patient leaves office/facility**											
82		**POST-SERVICE PERIOD**											
83		**Start: Patient leaves office/facility**											
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37								
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37								
93			L037D	RN/LPN/MTA	0.37								
96		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37								
99		**End: with last office visit before end of global period**											

	A	B	D	E	F	G	H	K	L	M	N	Q	R
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2						**CPT Code 90846**		**CPT Code 96202**		**CPT Code 96171**		**CPT Code 96203**	
3		***RUC Collaboration Website***				Family psychotherapy (without the patient present), 50 minutes		behavior modification/management training for guardians/caregivers of a patient with a		Health behavior intervention, family (without the patient present), face-to-face; each additional 15		Multiple-family group behavior modification/management training for guardians/caregivers	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 11 Specialty: APA, AACAP, AND**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 0.25**	**$ -**	**$ 8.65**	**$ -**	**$ 0.04**	**$ -**	**$ 0.03**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 0.09**	**$ -**	**$ 8.53**	**$ -**	**$ 0.04**	**$ -**	**$ -**	**$ -**
102	SK114	tissue (Kleenex)	1.7825	box		0.05		0.014		0.025	0		
103	SK005	assessment monitoring instruments	0.2875	item				2					
104	SK043	label for files-folders	0.0725	item				0					
105	SK057	paper, laser printing (each sheet)	0.0163	item				6					
109	*New*	2 inch 3 ring binder w/set of 8 dividers	7.91	each				0.99					
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 0.17**	**$ -**	**$ 0.12**	**$ -**	**$ -**	**$ -**	**$ 0.03**	**$ -**
112	EF042	One Couch and Two Chairs	1245.2602		0.00330458	50							
113													
114	EF043	Set of 8 chairs	4447.5435		0.011802564			10				2.50	
115													

AMA/Specialty Society RVS Update Committee Summary of Recommendations
April 2021

Emergency Department Services – Tab 12

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel revised the five emergency department visit codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on medical decision making.

Compelling Evidence
RUC members expressed concern with comparing the specialty society proposed values with the 2021 CMS values which were increased by CMS prior to receiving any input from the RUC. Although the RUC recommendations below are budget neutral, if making no adjustments to utilization assumptions for these revised codes, the RUC had concurred that it would be beneficial for the societies to still present compelling evidence arguments. The specialty societies presented two points for compelling evidence that the work of providing emergency department services has changed. First, a flaw in the methodology used in the current valuation; and second, a change in technology due to the implementation and more recent changes to EHRs leading to an increase in workflow disruption and task switching for emergency department services.

Flaw in the Methodology Used in the Current Valuation
In 2021, the revisions and updated relative value units (RVUs) went into effect for E/M office visit codes (99202-99215). Concurrently, even though the emergency department Services were not revised for the CPT cycle or reviewed by the RUC for 2021, CMS decided to increase the RVUs of the emergency department services to remain either equal or slightly higher than the corresponding level of a new patient office visit codes. In February 2021, the CPT Editorial Panel revised the five emergency department visit codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on medical decision making. Hypothetically, had the 2020 valuation of emergency department services remained in effect for 2021, that would have resulted in a rank order anomaly between office visit services and emergency medicine services. The RUC noted that the level of decision making required for 99282-99285 mirrors the corresponding new patient office visit codes 99202-99215. However, the methodology employed by CMS did not rely on a standardized survey or a crosswalk methodology.

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Change in Technology
According to National Medical Ambulatory Care Survey (NAMCS) data, in 2017, 90 percent of emergency physicians used electronic health records exclusively, 8 percent used them partially, and 2% used only paper records.[1] Relative to the 2016 data, which was not yet available when the emergency department services were reviewed by the RUC in 2018, the percentage of emergency physicians exclusively using electronic health records increased by 10 percent in only one year. Separately, in 2008, the corresponding numbers were 23 percent, 49 percent, and 28 percent. These differences demonstrate that the technology used to deliver emergency care has changed dramatically. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug interactions and, with increasing use of homeopathic substances, drug-substance interactions. The use of EHRs has increased physician work by increasing the time physicians spend documenting the medical record. The centralization of data is in the best interest of patients and will help support quality care; however, this centralization does increase the time that physicians spend reviewing patient information.

The specialties claimed that EHR adoption has led to a decrease in workflow efficiency. Emergency physician workflow has been particularly impacted by relatively more recent updates to EHR systems; these systems now generate large numbers of alerts for the provider to review. According to a recent study published in the Journal of Emergency Medicine on the impact of EMR alerts on emergency physician workflow, 78 percent of emergency department patient encounters involved alerts. 70 percent of that subset of patient encounters trigger multiple alerts. In addition, just 2 percent of these alerts result in a change in clinical management.[2] The specialties noted that this recent increase in workflow disruption and task switching for emergency department services has increased their intensity and complexity, the stress for providers and the risk for patients.

The RUC agrees that there is compelling evidence of 1) flaw in the methodology used in the current 2021 valuation of the services and 2) technology changes with the growth in use of EHRs and more recent changes to EHRs leading to an increase in workflow disruption and task switching for emergency department services.

Intra-service Only time on Date of Encounter
Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient. As was also done for the office visit services in 2019 and all other E/M services, all face-to-face and non-face-to-face physician or qualified healthcare professional (QHP) work on the date of the encounter was determined to be intra-service work and of the same intensity. In addition, as all the pre-service and post-service work for an emergency department visit would occur on the date of the encounter, all time is considered intra-time or total time. This is consistent with all inpatient and observation hospital codes, as the reporting of these inpatient services is based on total time on the date of encounter.

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[1] Rui P, Kang K. National Hospital Ambulatory Medical Care Survey: 2017 emergency department summary tables. National Center for Health Statistics. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf.
[2] Todd B et al. Impact of Electronic Medical Record Alerts on Emergency Physician Workflow and Medical Management. J Emerg Med. 2021 Mar;60(3):390-395. doi: https://doi.org/10.1016/j.jemermed.2020.10.017. Epub 2020 Dec 6. PMID: 33298357.

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99281 ***Emergency department visit for the evaluation and management of a patient, that may not require the presence of a physician or other qualified health care professional***
The RUC reviewed the survey results from 158 emergency physicians, pediatricians and advanced practice nurses for the lowest level emergency department visit code, CPT code 99281, and determined that the survey median value of 0.25 work RVUs appropriately accounts for the physician work typically required to perform this service. The RUC recommended an intra-service and total time of 10 minutes for 99281, 3 minutes higher than the total time of reference code 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal* (work RVU= 0.18, total time of 7 minutes). The RUC noted that the survey code has a disparate typical patient that may require slightly more time than the typical patient for 99211.

To further support a value of 0.25, the RUC compared the survey code to MPC code 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU= 0.24, intra-service and total time of 7 minutes) and noted that the survey code typically involves 3 more minutes of intra-service and total time, supporting a value of 0.25 for the survey code. The RUC concluded that CPT code 99281 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 0.25 for CPT code 99281.**

99282 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making***
The RUC reviewed the survey results from 162 emergency medicine physicians, pediatricians and advanced practice nurses and determined that a value between the survey 25th percentile of 0.80 and survey median of 0.99 work RVUs would appropriately account for the work required to perform this service. Therefore, the RUC recommends crosswalking CPT code 99282 to top key reference service code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU= 0.93, total time of 20 minutes). The RUC noted that this value is also the current CMS value. The RUC recommends 18 minutes of intra-service and total time, as supported by the survey. Although, both services involve straightforward medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving somewhat less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress.

For additional support, the RUC compared the survey code to CPT code 73700 *Computed tomography, lower extremity; without contrast material* (work RVU= 1.00, total time of 20 minutes) and noted that the survey code typically involves slightly less time and slightly less physician work. The RUC concluded that CPT code 99282 should be valued based on a direct work RVU crosswalk to CPT code 99202 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 0.93 for CPT code 99282.**

99283 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making***

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The RUC reviewed the survey results from 163 emergency medicine physicians, pediatricians and advanced practice nurses and determined that a value between the survey 25th percentile of 1.50 and survey median of 1.75 would appropriately account for the work required to perform this service. Therefore, the RUC recommends a direct work RVU crosswalk for CPT code 99283 to top key reference service code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU= 1.60, total time of 35 minutes). The RUC noted that this value is also the current CMS value. The RUC recommends 30 minutes of intra-service and total time. Although, both services involve a low level of medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving somewhat less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress.

For additional support, the RUC also compared the survey code to MPC code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* (work RVU= 1.60, total time of 30 minutes) and noted that both services involve the same amount of total time and a similar amount of physician work. The RUC concluded that CPT code 99283 should be valued based on a direct work RVU crosswalk to CPT code 99203 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 1.60 for CPT code 99283.**

99284 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making***

The RUC reviewed the survey results from 163 emergency medicine physicians, pediatricians and advanced practice nurses and determined that the survey median overestimated the work typically required to perform this service. After thorough discussion, the RUC recommends the survey 25th percentile work RVU of 2.60 for CPT code 99284 which is also the same work value as top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes). The RUC recommends 40 minutes of intra-service and total time as supported by the survey. The RUC compared the survey code to top key reference code 99204 and noted that, although it concurs with the presenting specialties that 99284 is a more intense service to perform, 99204 typically involves 20 more minutes of total time. Although both services involve moderate medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress. The RUC concluded that CPT code 99284 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.60 for CPT code 99284.**

99285 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making***

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The RUC reviewed the survey results for 162 emergency medicine physicians, pediatricians and advanced practice nurses for the highest level emergency department visit code, CPT code 99285, and determined that the survey median value of 4.00 appropriately accounts for the physician work required to perform this service. The RUC noted that this value is also the current CMS value. The RUC recommends 60 minutes of intra-service and total time, 5 minutes more than the current time assigned to this service. The RUC noted that a work value of 4.00 would appropriately assign 99285 a work value that reflects an intensity higher than 99284. The RUC compared the survey code to critical care visits 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes) and add-on code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU=2.25, total time of 30 minutes) and noted that a value of 4.00 for the highest level ED visit code maintains appropriate relativity with critical care services. The RUC also compared the survey code to top key reference service code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU=3.50, total time of 88 minutes) and noted that although both services involve a high level of medical decision making and the reference code involves more total time, it is appropriate to assign the highest level ED visit code a higher work value. 76 percent of the survey respondents that selected 99205 as their top key reference service had indicated that a level 5 emergency department visit is more intense and complex to perform (with another 11 percent rating 99285 as somewhat more intense/complex). The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress. The RUC concluded that CPT code 99285 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 4.00 for CPT code 99285.**

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

Practice Expense
No direct practice expense inputs are recommended for CPT codes 99281-99285 as they are facility-only services.

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Evaluation and Management
Emergency Department Services
New or Established Patient

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For critical care services provided in the emergency department, see Critical Care notes and 99291, 99292. Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes, and critical care services are provided.

For evaluation and management services provided to a patient in ~~an~~ observation status ~~area of a hospital,~~ see 99221, 99222, 99223 for the initial observation encounter and 99231, 99232, 99233, 99238, 99239 for subsequent observation or inpatient encounters.~~99217-99220.~~

For hospital inpatient or observation ~~or inpatient~~ care services (including admission and discharge services), see 99234-99236.

To report services when a patient is admitted to hospital inpatient, or observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient or Observation Care** or **Initial Nursing Facility Care**.

For procedures or services identified by a CPT code that may be separately reported on the same date, use the appropriate CPT code. Use the appropriate modifier(s) to report separately identifiable evaluation and management services and the extent of services provided in a surgical package.

If a patient is seen in the emergency department for the convenience of a physician or other qualified health care professional, use office or other outpatient services codes (99202-99215).

Coding Tip

Time as a Factor in the Emergency Department Setting

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. ~~Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.~~

CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time

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▲99281	H1	**Emergency department visit** for the evaluation and management of a patient, ~~which requires these 3 key components:~~ that may not require the presence of a physician or other qualified health care professional. • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor.~~	XXX	0.25

▲99282	H2	**Emergency department visit** for the evaluation and management of a patient, ~~which requires these 3 key components:~~ which requires a medically appropriate history and/or examination and straightforward medical decision making. • ~~**An expanded problem focused history;**~~ • ~~**An expanded problem focused examination; and**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity.~~	XXX	0.93 (No change)

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▲99283	H3	**Emergency department visit** for the evaluation and management of a patient, ~~which requires these 3 key components:~~ which requires a medically appropriate history and/or examination and low level of medical decision making. • ~~**An expanded problem focused history;**~~ • ~~**An expanded problem focused examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity.~~	XXX	1.60 (No change)

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▲99284	H4	**Emergency department visit** for the evaluation and management of a patient, ~~which requires these 3 key components:~~ which requires a medically appropriate history and/or examination and moderate level of medical decision making. • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.~~	XXX	2.60
▲99285	H5	**Emergency department visit** for the evaluation and management of a patient, ~~which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:~~ which requires a medically appropriate history and/or examination and high level of medical decision making. • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.~~	XXX	4.00 (No change)

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Coding Tip

Emergency Department Classification of New vs Established Patient

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, New and Established Patient

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CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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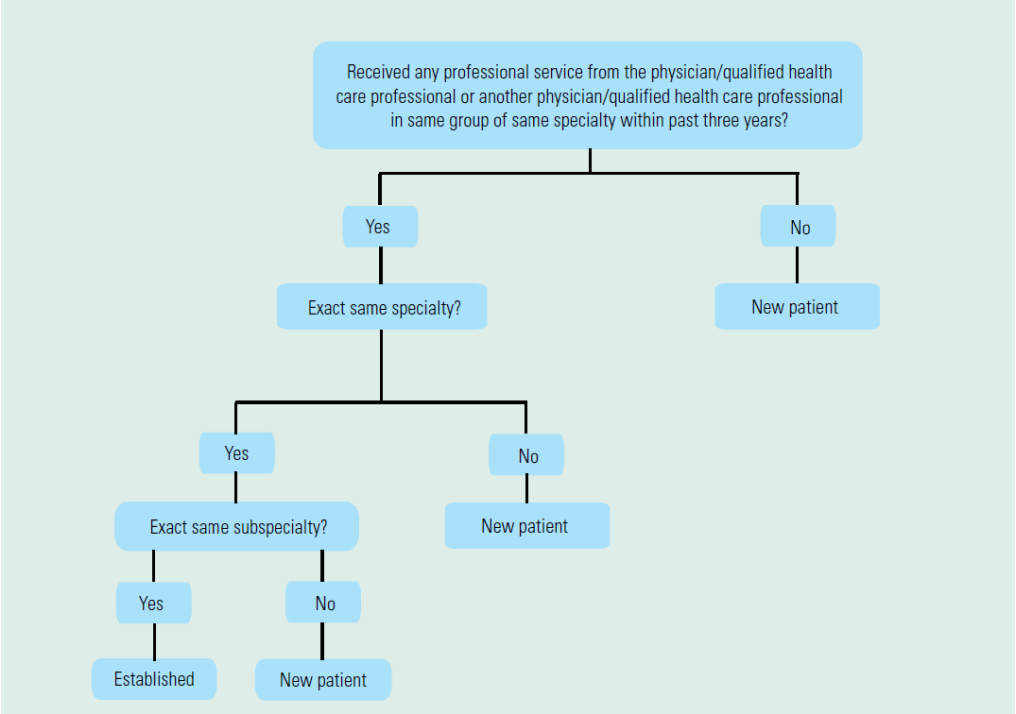
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99281 Tracking Number H1 Original Specialty Recommended RVU: **0.25**
Presented Recommended RVU: **0.25**
Global Period: XXX Current Work RVU: **0.48** RUC Recommended RVU: **0.25**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, that may not require the presence of a physician or other qualified health care professional.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department for suture removal after repair of a forearm laceration by a different provider in another location. There are no complaints, and the wound appears well healed.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: .

Description of Intra-Service Work: Obtain a medically appropraiate history, including interviews with patient, prehospital personnel, family members, and caregivers in person or by phone as needed, and perform a medcially appropropriate physical examination. Formulate a diagnosis and develop a treatment plan (MDM is not a component). Enter orders in the EHR during the evaluation of the patient and begin the documentation. Formulate a discharge plan. Discuss follow-up and reasons for return to the emergency department. Explain any prescriptions or other treatments and work, school, or activity restrictions. Answer patient and patient caregiver questions.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Steven Krug, MD, FAAP, AAP Advisor; Jordan Celeste, MD, FACEP, ACEP Advisor; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, ANA Advisor; Elisabeth Volpert DNP, APRN, FNP-C, ANA Advisor					
Specialty Society(ies):	American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association					
CPT Code:	99281					
Sample Size:	8316	**Resp N:**	158			
Description of Sample:	Emergency physicians, pediatricians, and advanced practice nurses.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**15.00**	50.00	1000.00
Survey RVW:	0.17	0.18	**0.25**	0.50	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	7.00	**10.00**	15.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99281	**Recommended Physician Work RVU: 0.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99211	XXX	0.18	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit: intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
72074	XXX	0.25	**RUC Time**	4,505

CPT Descriptor 2 Radiologic examination, spine thoracic, minimum of 4 views

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 102 **% of respondents:** 64.9 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 13.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99281	Top Key Reference CPT Code: 99211	2nd Key Reference CPT Code: **99212**
Median Pre-Service Time	0.00	0.00	2.00
Median Intra-Service Time	10.00	5.00	11.00
Median Immediate Post-service Time	0.00	2.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**10.00**	**7.00**	**16.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	5%	5%	72%	15%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	70%	22%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	77%	13%

Physical effort required	12%	74%	14%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	72%	17%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	9%	66%	23%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	76%	10%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	71%	25%
Physical effort required	4%	66%	30%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	57%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The current 99281 RVUw is 0.48. Our combined survey median was 0.25 with a 25th percentile of 0.18. The intraservice time has increased from the current 8 minutes to the survey median of 10 minutes. The intensity has dropped with new code descriptor, which may not require the presence of a physician or other qualified health care professional, such as a well healed wound recheck. The WPUT is about the same for the first key reference

service 99211 (0.025 vs. 0.026). The majority of respondents, with seventy two percent, said the intensity of 99281 is the same as 99211. Only 15 % said it was somewhat more, and zero% said it was much more. Of note, the intensity dropped compared to the current 99281 intensity values (0.032 vs. 0.025). **We are asking for a slightly longer intraservice time of ten minutes and about half the current work value of 99281 (0.48) at 0.25.**

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDV	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99211	XXX	Office or other outpatient visit for the evaluation and management of an established patient, that may	102	0.027	0.026			0.18			7						5			2					
2nd REF	99212	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which	21	0.053	0.044			0.70			16	2					11			3					
CURRENT	99281	XXX	Emergency department visit for the evaluation and		0.040	0.032			0.48			15	2					8			5					
SVY	99281	XXX	Emergency department visit for the evaluation and	158	0.025	0.025	0.17	0.18	0.25	0.50	10.00	10				0	7	10	15	50		0	2	15	50	1000
REC	99281	XXX	Emergency department visit for the evaluation and		0.025	0.025			0.25			10						10								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 2019 Medicare claims data

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine — How often? Commonly

Specialty Pediatric Medicine — How often? Sometimes

Specialty Nurse Practitioner — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 270920

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents 20% of ED claims

Specialty Emergency Medicine Frequency 118635 Percentage 43.78 %

Specialty Nurse Practitioner Frequency 36818 Percentage 13.58 %

Specialty Pediatric Medicine Frequency 270 Percentage 0.01 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 67,730
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data frequency

Specialty Emergency Medicine Frequency 29665 Percentage 43.79 %

Specialty Nurse Practitioner Frequency 9211 Percentage 13.59 %

Specialty Pediatric Medicine Frequency 677 Percentage 0.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Emergency room visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99281

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99282 Tracking Number H2 Original Specialty Recommended RVU: **0.93**
Presented Recommended RVU: **0.93**
Global Period: XXX Current Work RVU: **0.93** RUC Recommended RVU: **0.93**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department with a self-limited or minor problem.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: .

Description of Intra-Service Work: Obtain a medically appropriate history, including interviews with patient, prehospital personnel, and family members in person or by phone as needed. Perform a medically appropriate examination; formulate a diagnosis and develop a treatment plan (MDM of straightforward complexity). Enter orders in the computer during the evaluation of the patient and begin the medical record. Explain any prescriptions required along with discharge instructions and any follow-up care required, including reasons to return to the ED. Answer patient and patient caregiver questions.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Steven Krug, MD, FAAP, AAP Advisor; Jordan Celeste, MD, FACEP, ACEP Advisor; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, ANA Advisor; Elisabeth Volpert DNP, APRN, FNP-C,ANA Advisor					
Specialty Society(ies):	American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association;					
CPT Code:	99282					
Sample Size:	8316	**Resp N:**	162			
Description of Sample:	Emergency physicians, pediatricians, and advanced practice nurses.					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	20.00	**73.00**	200.00	2500.00	
Survey RVW:	0.18	0.80	**0.99**	1.20	20.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	12.00	**18.00**	20.00	70.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99282	**Recommended Physician Work RVU: 0.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93307	XXX	0.92	**RUC Time**	4,989

CPT Descriptor 1 93307 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography 0.92 5 15 5 25 0.0464 XXX

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95819	XXX	1.08	**RUC Time**	68,372

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 60 **% of respondents:** 37.2 **%**

Number of respondents who choose 2nd Key Reference Code: 47 **% of respondents:** 29.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 99282	**Top Key Reference CPT Code:** 99202	**2nd Key Reference CPT Code:** **99212**
Median Pre-Service Time	0.00	2.00	2.00
Median Intra-Service Time	18.00	15.00	11.00
Median Immediate Post-service Time	0.00	3.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**18.00**	**20.00**	**16.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	3%	1%	56%	36%	1%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	55%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	66%	28%
Physical effort required	9%	70%	21%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	65%	28%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	53%	40%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	55%	41%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	59%	37%
Physical effort required	2%	68%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	57%	37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The current 99282 RVUw is 0.93 Our combined survey median is 0.99 with a 25th percentile of 0.80. 99282 Intra time increased from 10 to 18 minutes while the total time dropped by one minute. The 99282 WPUT is greater than the forest key reference service 99202 (0.055 vs. 0.047). Thirty six percent of respondents said this intensity/complexity of 99282 was somewhat more than 99202. **We are asking to retain the current value of 99282 at 0.93 to maintain the current relativity with 99202 in 2021.** Both RUC and CMS have considered these services equivalent in multiple prior considerations of these codes.

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDV	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a	60	0.055	0.047			0.93			20	2					15			3					
2nd REF	99212	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which	47	0.053	0.044			0.70			16	2					11			3					
CURRENT	99282	XXX	Emergency department visit for the evaluation and		0.073	0.049			0.93			19	3					10			6					
SVY	99282	XXX	Emergency department visit for the evaluation and	162	0.055	0.055	0.18	0.80	0.99	1.20	20.00	18				5	12	18	20	70		0	20	73	200	2500
REC	99282	XXX	Emergency department visit for the evaluation and		0.052	0.052			0.93			18						18								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 2019 Medicare claims data

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine How often? Commonly

Specialty Pediatric Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1409984
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents 20% of all ED claims

Specialty Emergency Medicine	Frequency 802139	Percentage 56.88 %
Specialty Nurse Practitioner	Frequency 136627	Percentage 9.68 %
Specialty Pediatric Medicine	Frequency 1409	Percentage 0.01 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 352,496 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data frequency

Specialty Emergency Medicine	Frequency 200570	Percentage 56.89 %
Specialty Nurse Practitioner	Frequency 34192	Percentage 9.69 %
Specialty Pediatric Medicine	Frequency 352	Percentage 0.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Emergency room visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99282

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99283 Tracking Number H3 Original Specialty Recommended RVU: **1.60**
Presented Recommended RVU: **1.60**
Global Period: XXX Current Work RVU: **1.60** RUC Recommended RVU: **1.60**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department with a stable chronic illness of acute uncomplicated injury.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: .

Description of Intra-Service Work: Obtain a medically appropriate history, including interviews with patient, physician office, nursing home, or EMS personnel, and family members in person or by phone as needed, and perform a medically appropriate examination. Formulate a diagnosis and treatment plan (MDM of low complexity). Enter orders in the computer during the evaluation of the patient and begin the medical record. Communicate with other health care professionals as necessary during the encounter. Evaluate response to therapy, review data from diagnostic testing, and reassess the patient. Formulate a discharge plan, including medication and other treatments as well as follow-up planning. Explain any prescriptions or other therapies required along with discharge instructions, activity limitations, and any follow-up care required, including reasons to return to the ED. Answer patient and patient caregiver questions.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Steven Krug, MD, FAAP, AAP Advisor; Jordan Celeste, MD, FACEP, ACEP Advisor; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, ANA Advisor; Elisabeth Volpert DNP, APRN, FNP-C. ANA Advisor					
Specialty Society(ies):	American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association					
CPT Code:	99283					
Sample Size:	8316	**Resp N:**	163			
Description of Sample:	Emergency physicians, pediatricians, and advanced practice nurses.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	86.00	**280.00**	600.00	18000.00
Survey RVW:	0.22	1.50	**1.75**	2.00	30.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**30.00**	35.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99283	**Recommended Physician Work RVU: 1.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95861	XXX	1.54	**RUC Time**	44,204

CPT Descriptor 1 Needle electromyography; 2 extremities with or without related paraspinal areas

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93351	XXX	1.75	**RUC Time**	151,068

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 63 **% of respondents:** 38.6 **%**

Number of respondents who choose 2nd Key Reference Code: 32 **% of respondents:** 19.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99283	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	0.00	5.00	5.00
Median Intra-Service Time	30.00	25.00	15.00
Median Immediate Post-service Time	0.00	5.00	6.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**35.00**	**26.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	17%	63%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	27%	70%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	33%	63%
Physical effort required	4%	39%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	25%	72%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	37%	50%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	40%	51%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	43%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	34%	66%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The current 99283 RVUw is 1.60. Our combined survey median is 1.75 with a 25th percentile of 1.50 99283 Intra time is higher than the first key reference service 99203 at 30 vs. 25 minutes. WPUT for 99283 is greater than 99203 (0.058 vs. 0.046). Sixty three percent or respondents said this intensity/complexity was somewhat more than 99203. Fourteen percent said intensity/complexity was much more. **We are asking to maintain the current value of 99283 as compared to 99203 at 1.60 to maintain relativity across the code families as previously approved by RUC and CMS multiple times.**

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDV	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	63	0.055	0.046			1.60			35	5					25			5					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and management of an	33	0.054	0.043			1.30			30	5					20			5					
CURRENT	99283	XXX	Emergency department visit for the evaluation and		0.084	0.053			1.60			30	5					15			10					
SVY	99283	XXX	Emergency department visit for the evaluation and	163	0.058	0.058	0.22	1.50	1.75	2.00	30.00	30				5	20	30	35	120		0	86	280	600	18000
REC	99283	XXX	Emergency department visit for the evaluation and		0.053	0.053			1.60			30						30								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 2019 Medicare claims data

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine How often? Commonly

Specialty Pediatric Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 10978840
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents 20% of ED claims

Specialty Emergency Medicine	Frequency 6630121	Percentage 60.38 %
Specialty Nurse Practitioner	Frequency 1107764	Percentage 10.08 %
Specialty Pediatric Medicine	Frequency 10978	Percentage 0.01 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,744,710 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data frequency

Specialty Emergency Medicine	Frequency 1657804	Percentage 60.39 %
Specialty Nurse Practitioner	Frequency 277215	Percentage 10.09 %
Specialty Pediatric Medicine	Frequency 2744	Percentage 0.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Emergency room visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99283

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99284 Tracking Number H4 Original Specialty Recommended RVU: **2.74**
Presented Recommended RVU: **2.74**
Global Period: XXX Current Work RVU: **2.74** RUC Recommended RVU: **2.60**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Obtain a medically appropriate history, including interviews with patient, physician office, nursing home, or EMS personnel, and family members and caregivers present or by phone as needed. Perform a medicaly appropriate physical examination. Formulate a diagnosis and treatment plan (MDM of moderate complexity). Enter orders in the EHR during the evaluation of the patient and begin the medical record. Communicate with other health care professionals as necessary during the encounter. Review data from diagnostic testing and evaluate response to therapy by reassessing the patient and then adjusting the treatment plan accordingly. Formulate a discharge plan, included needed medications, therapies, and work or activity restrictions and recommendations. Arrange and review follow-up. Explain any prescriptions and treatments required along with discharge instructions and any follow-up care required, including reasons to return to the ED. Answer patient and patient caregiver questions.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Steven Krug, MD, FAAP, AAP Advisor; Jordan Celeste, MD, FACEP, ACEP Advisor; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, ANA Advisor; Elisabeth Volpert DNP, APRN, FNP-C, ANA Advisor					
Specialty Society(ies):	American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association					
CPT Code:	99284					
Sample Size:	8316	**Resp N:**	163			
Description of Sample:	Emergency physicians, pediatricians, and advanced practice nurses.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	120.00	**325.00**	700.00	10000.00
Survey RVW:	1.00	2.60	**2.95**	3.50	40.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	30.00	**40.00**	50.00	150.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99284	**Recommended Physician Work RVU: 2.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	116,690

CPT Descriptor 1 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
10030	000	2.75	**RUC Time**	8,525

CPT Descriptor 2 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 74 **% of respondents:** 45.6 **%**

Number of respondents who choose 2nd Key Reference Code: 26 **% of respondents:** 16.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99284	Top Key Reference CPT Code: 99204	2nd Key Reference CPT Code: **99215**
Median Pre-Service Time	0.00	10.00	10.00
Median Intra-Service Time	40.00	40.00	45.00
Median Immediate Post-service Time	0.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**60.00**	**70.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	1%	16%	36%	45%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	23%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	23%	73%

Physical effort required	4%	24%	72%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	16%	82%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	15%	38%	38%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	23%	66%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	27%	70%
Physical effort required	3%	38%	59%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	7%	86%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The current 99284 RVUw is 2.74. Our combined survey median is 2.95 with a 25th percentile of 2.60. 99284 Intra time is the same as the first key reference service of 99204 at 40 minutes. Maintaining the current work RVU driven WPUT for 99284 at 0.069 (which is lower than the survey median of 0.074) is higher than that of 99204 at 0.43. This is supported as thirty six percent of respondents said this intensity/complexity of 99284 was somewhat more than 99204. And forty five

percent said it was much more intense/complex. In addition, to maintain historic relativity to 99204, 99284 should be raised by 6.9 percent to **2.74**. We are a**sking to maintain the current CMS value of 2.74 to maintain relativity across the families as previously approved by RUC and the value approved by CMS in 2021.**

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDV	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a	75	0.054	0.043			2.60			60	10					40			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which	26	0.050	0.040			2.80			70	10					45			15					
CURRENT	99284	XXX	Emergency department visit for the evaluation and		0.106	0.069			2.74			40	6					22			12					
SVY	99284	XXX	Emergency department visit for the evaluation and	163	0.074	0.074	1.00	2.60	2.95	3.50	40.00	40				6	30	40	50	150		0	120	325	700	10000
REC	99284	XXX	Emergency department visit for the evaluation and		0.069	0.069			2.74			40						40								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 2019 Medicare claims data

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine — How often? Commonly

Specialty Pediatric Medicine — How often? Sometimes

Specialty Nurse Practitioner — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 21,662,600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents 20% of all ED claims

Specialty Emergency Medicine — Frequency 15293795 — Percentage 70.59 %

Specialty Nurse Practitioner — Frequency 1557540 — Percentage 7.18 %

Specialty Pediatric Medicine Frequency 21662 Percentage 0.01 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,415,650 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data frequency

Specialty Emergency Medicine Frequency 3823448 Percentage 70.59 %

Specialty Nurse Practitioner Frequency 389926 Percentage 7.19 %

Specialty Pediatric Medicine Frequency 5415 Percentage 0.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Emergency room visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99284

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99285 Tracking Number H5 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: XXX Current Work RVU: **4.00** RUC Recommended RVU: **4.00**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: .

Description of Intra-Service Work: Obtain a medically appropriate history, including interviews with patient, physician office, nursing home, or EMS personnel, and family members and caregivers present or by phone. Perform a medically appropriate physical examination. Formulate a diagnosis and treatment plan (MDM of high complexity). Enter orders in the EHR during the evaluation of the patient and begin the medical record. Review data from diagnostic testing, including labs, imaging, and imaging interpretation. Reassess the patient multiple times, order additional diagnostic tests as indicated, and adjust treatment plan accordingly. Communicate with other health care professionals as necessary for consultation or care coordination during the encounter. Formulate a disposition plan, including communication to and coordination with an inpatient team if appropriate, or more typically, prepare a discharge plan, with prescriptions and additional therapies, work or activity restrictions, and arrange follow-up appointments or testing as needed. Explain any prescriptions or other therapies as required along with discharge instructions, expected course, and any follow-up care required, including reasons to return to the ED. Answer patient and patient caregiver questions.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Steven Krug, MD, FAAP, AAP Advisor; Jordan Celeste, MD, FACEP, ACEP Advisor; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, ANA Advisor; Elisabeth Volpert DNP, APRN, RNP-C, ANA Advisor					
Specialty Society(ies):	American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association					
CPT Code:	99285					
Sample Size:	8316	**Resp N:**	162			
Description of Sample:	Emergency physicians, pediatricians, and advanced practice nurses.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	51.00	**218.00**	500.00	12000.00
Survey RVW:	1.50	3.71	**4.00**	4.50	50.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	45.00	**60.00**	72.00	175.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99285	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90792	XXX	4.16	**RUC Time**	586,327

CPT Descriptor 1 Psychiatric diagnostic evaluation with medical services

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92950	000	4.00	**RUC Time**	68,953

CPT Descriptor 2 CPR

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 94 **% of respondents:** 58.3 **%**

Number of respondents who choose 2nd Key Reference Code: 20 **% of respondents:** 12.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 99285	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99215**
Median Pre-Service Time	0.00	14.00	10.00
Median Intra-Service Time	60.00	59.00	45.00
Median Immediate Post-service Time	0.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**88.00**	**70.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	1%	2%	8%	11%	76%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	12%	82%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	3%	15%	82%
Physical effort required	3%	15%	82%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	7%	90%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	15%	10%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	20%	80%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	10%	85%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The current 99285 RVUw is 4.00. Our combined survey median is 4.00 with a 25th percentile of 3.71. 99285 Intra time is slightly higher than 99205 at 60 vs. 59 minutes. WPUT for 99285 is higher at 0.067 vs. 0.040. While eleven percent of respondents said this intensity/complexity was somewhat more than 99204 a robust Seventy six percent said it was much more intense/complex than 99205.

To maintain historic relativity of 99285to 99205, the RUC should raise the code by 10.41 percent to **4.20.** **However, we are asking for the current value at 4.00 as this is supported by both the 2021 and the 2018 RUC surveys, and this to maintains relativity across the ED and new office or other outpatient code families as previously approved by RUC and CMS multiple times, and as the value approved by CMS in 2021.**

							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDV	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a	95	0.048	0.040			3.50			88	14					59			15					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which	20	0.050	0.040			2.80			70	10					45			15					
CURRENT	99285	XXX	Emergency department visit for the evaluation and		0.115	0.073			4.00			55	9					30			16					
SVY	99285	XXX	Emergency department visit for the evaluation and	162	0.067	0.067	1.50	3.71	4.00	4.50	50.00	60				3	45	60	72	175		0	51	218	500	12000
REC	99285	XXX	Emergency department visit for the evaluation and		0.067	0.067			4.00			60						60								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 2019 Medicare claims data

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine — How often? Commonly

Specialty Pediatric Medicine — How often? Sometimes

Specialty Nurse Practitioner — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 46057096
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents 20% of all ED claims

Specialty Emergency Medicine — Frequency 37720769 — Percentage 81.90 %

Specialty Nurse Practitioner — Frequency 1842283 — Percentage 3.99 %

Specialty Pediatric Medicine Frequency 46057 Percentage 0.10 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data frequency

Specialty Emergency Medicine Frequency 9430190 Percentage 81.90 %

Specialty Nurse Practitioner Frequency 460570 Percentage 4.00 %

Specialty Pediatric Medicine Frequency 11514 Percentage 0.10 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Emergency room visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99285

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Emergency Department Services
TAB: 12

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99211	XXX	Office or other outpatient visit for the evaluation and management of an established patient, that may not require	2019	102	0.027	0.026			0.18			7						5			2					
2nd REF	99212	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	2019	21	0.053	0.044			0.70			16	2					11			3					
CURRENT	99281	XXX	Emergency department visit for the evaluation and	2018		0.040	0.032			0.48			15	2					8			5					
SVY	99281	XXX	Emergency department visit for the evaluation and		158	0.025	0.025	0.17	0.18	0.25	0.50	10.00	10				0	7	10	15	50		0	2	15	50	1000
REC	99281	XXX	Emergency department visit for the evaluation and			0.025	0.025			0.25			10						10								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically	2019	60	0.055	0.047			0.93			20	2					15			3					
2nd REF	99212	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	2019	47	0.053	0.044			0.70			16	2					11			3					
CURRENT	99282	XXX	Emergency department visit for the evaluation and	2018		0.073	0.049			0.93			19	3					10			6					
SVY	99282	XXX	Emergency department visit for the evaluation and		162	0.055	0.055	0.18	0.80	0.99	1.20	20.00	18				5	12	18	20	70		0	20	73	200	2500
REC	99282	XXX	Emergency department visit for the evaluation and			0.052	0.052			0.93			18						18								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new patient,	2019	63	0.055	0.046			1.60			35	5					25			5					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and management of an established	2019	33	0.054	0.043			1.30			30	5					20			5					
CURRENT	99283	XXX	Emergency department visit for the evaluation and	2018		0.084	0.053			1.60			30	5					15			10					
SVY	99283	XXX	Emergency department visit for the evaluation and		163	0.058	0.058	0.22	1.50	1.75	2.00	30.00	30				5	20	30	35	120		0	86	280	600	18000
REC	99283	XXX	Emergency department visit for the evaluation and			0.053	0.053			1.60			30						30								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically	2019	75	0.054	0.043			2.60			60	10					40			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	2019	26	0.050	0.040			2.80			70	10					45			15					
CURRENT	99284	XXX	Emergency department visit for the evaluation and	2018		0.106	0.069			2.74			40	6					22			12					
SVY	99284	XXX	Emergency department visit for the evaluation and		163	0.074	0.074	1.00	2.60	2.95	3.50	40.00	40				6	30	40	50	150		0	120	325	700	10000
REC	99284	XXX	Emergency department visit for the evaluation and			0.065	0.065			2.60			40						40								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically	2019	95	0.048	0.040			3.50			88	14					59			15					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and management of an established patient, which requires a	2019	20	0.050	0.040			2.80			70	10					45			15					
CURRENT	99285	XXX	Emergency department visit for the evaluation and	2018		0.115	0.073			4.00			55	9					30			16					
SVY	99285	XXX	Emergency department visit for the evaluation and		162	0.067	0.067	1.50	3.71	4.00	4.50	50.00	60				3	45	60	72	175		0	51	218	500	12000
REC	99285	XXX	Emergency department visit for the evaluation and			0.067	0.067			4.00			60						60								

March 26, 2021

Ezequiel Silva III, MD
Chairperson, AMA/Specialty Society Relative Value Scale Update Committee
Relative Value Systems, American Medical Association
330 N Wabash, Suite 39300
Chicago, IL 60611

RE: Direct Practice Expense Inputs for Tab 12 (99281-99285; H1-H5)

Dear Doctor Silva:

Codes 99281-99285 (*Emergency Department Services)* are among the codes being considered during the April 2021 RUC meeting.

The American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and American Nurses Association (ANA) have conducted a physician and other qualified healthcare provider work survey for 99821-99825 and developed a work RVU recommendation based on the survey results. However, since the service described by codes 99821-99825 is one that typically occurs in the facility setting, we recommend no direct practice expense inputs for codes 99821-99825.

If you have any questions, please contact Linda Walsh, AAP staff at 630/626-6331 or lwalsh@aap.org.

Thank you.

Sincerely,
Steven Krug, MD, FAAP
AAP RUC Advisor

Jordan Celeste, MD, FACEP
ACEP RUC Advisor

Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA
ANA RUC/HPAC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Nursing Facility Services – Tab 13

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted the annual nursing facility assessment code and revised seven nursing facility codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of a nursing facility visit service code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The nursing facility services were surveyed for the April 2021 RUC meeting. The survey time captured includes pre-service time 1-day before the date of encounter, intra-service time is all the time on the date of encounter and post-service time is 3-days after the date of encounter.

The RUC noted that all the of these services are typically performed in the skilled nursing facility which requires a higher level of care than the nursing facility.

COMPELLING EVIDENCE

In April 2021, the RUC met to review the nursing facility changes. The specialty societies indicated that there is compelling evidence based on flawed methodology. The specialty societies reviewed the methodology used by the RUC in 2007 to arrive at the current values. That methodology was inconsistent among the codes in the family and was not based on survey values or direct crosswalks. For example, 99304, the initial nursing visit code requiring low level medical decision making was valued based on the sum of the value of 99203, a new patient visit also requiring a low level of medical decision making, plus one-fourth the value of 99374, physician supervision of a patient under the care of a home health

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agency. The RUC justified its recommendations for all the initial nursing visit codes by dividing the median time of the nursing visit code by the median time of the comparable subsequent hospital visit code, multiplying that fraction by the work RVU of the hospital visit code and adding one-fourth of 99374. Similarly, the methodology for valuing the subsequent nursing visit codes was inconsistent and differed from the methodology used for the initial visit codes. The RUC agreed that there is compelling evidence that the previous valuation was based on flawed methodology.

INITIAL NURSING FACILITY CARE

99304 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.***
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 6 minutes of pre-service time, 25 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99304 describing straightforward/low medical decision-making is appropriately slightly less physician work than CPT code 99203.

The RUC also compared 99304 to the second top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 15 minutes intra-service time and 20 minutes total time) and determined that CPT code 99304 requires much more physician work and time, thus is valued appropriately. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99304 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes of intra-service time) and code 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.50 for CPT code 99304.**

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99305 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.***
The RUC reviewed the survey results from 204 physicians and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 35 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60, 40 minutes intra-service time and 60 minutes total time) and determined that 99305 requires slightly less physician work and time to perform.

The RUC also compared 99305 to the second top key reference service, 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99305 requires much more physician work and time than 99203. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99305 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes of intra-service time) and code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU = 2.40 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.50 for CPT code 99305.**

99306 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 208 physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service time, 50 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50, 59 minutes intra-service time and 88 minutes total time) and determined that these services require the same physician work and should be valued the same. Although 99306 requires slightly less physician time, both require a high level of medical decision making and similar typical patients who require intensive management.

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For additional support, the RUC referenced MPC code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.57 and 70 minutes of intra-service/total time) and code 50328 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each* (work RVU = 3.50 and 45 minutes of intra-service/total time), which require similar physician work and time. **The RUC recommends a work RVU of 3.50 for CPT code 99306.**

SUBSEQUENT NURSING FACILITY CARE

99307 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.***
The RUC reviewed the survey results from 196 physicians and determined that the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 1 minutes of pre-service time, 12 minutes of intra-service time and 1 minute of post-service time.

The RUC compared the surveyed code to the top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined that these services require the same straightforward level of medical decision making, the same physician work and similar physician time to perform, thus should be valued the same.

The RUC also compared 99307 to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that 99307 requires much less physician work, time and a lower level of medical decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 15 minutes of intra-service time) and code 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 15 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 0.70 for CPT code 99307.**

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99308 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***
The RUC reviewed the survey results from 214 physicians and determined that the survey 25th percentile work RVU of 1.30 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes of pre-service time, 18 minutes of intra-service time and 4 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that these services require the same low level of medical decision making, the same physician work and similar physician time to perform.

The RUC also compared 99308 to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that 99308 requires less physician work, time and level of medical decision making to perform than 99214, thus is valued appropriately.

For additional support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes of intra-service time) and code 74280 *Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered* (work RVU = 1.26 and 20 minutes of intra-service time), which require similar physician work and time.
The RUC recommends a work RVU of 1.30 for CPT code 99308.

99309 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 217 physicians and determined that the 25th percentile work RVU of 1.92 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of pre-service time, 30 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that these services require the same moderate level of medical decision making, physician work and physician time to perform.

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The RUC also compared 99309 to the second top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that 99309 requires less physician work, time and level of decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 30 minutes of intra-service time) and code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.92 for CPT code 99309.**

99310 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 2.80 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 45 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that these services require the same high level of medical decision making, physician work and physician time to perform, thus should be valued the same.

The RUC also compared 99310 to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50, 40 minutes intra-service time and 70 minutes total time) and determined 99310 requires less physician work and the typical patient is less intense than the critical care service. Thus, CPT code 99310 is appropriately valued lower than 99291.

For additional support, the RUC referenced MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60 and 40 minutes of intra-service time) and code 75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* (work RVU = 2.60 and 45 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.80 for CPT code 99310.**

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NURSING FACILITY CARE DISCHARGE DAY MANAGEMENT

99315 ***Nursing facility discharge day management; 30 minutes or less***
99316 ***Nursing facility discharge day management; more than 30 minutes***
The RUC reviewed CPT codes 99315 and 99316 and determined to maintain the proper rank order, these services should be reviewed with the hospital discharge day management codes, 99238 and 99239, in October 2021**. The RUC recommends to table review of CPT codes 99315 and 99316 until October 2021.**

CPT Descriptor Time
The RUC recommends the following times for the CPT descriptors based on the survey medians. The time in the CPT descriptors are rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code		Time on the Date of Encounter Recommendation to CPT
99304	Initial nursing facility care, per day, straightforward or low MDM	**25**
99305	Initial nursing facility care, per day, moderate MDM	**35**
99306	Initial nursing facility care, per day, high MDM	**45**
99307	Subsequent nursing facility care, per day, straightforward MDM	**10**
99308	Subsequent nursing facility care, per day, low MDM	**15**
99309	Subsequent nursing facility care, per day, moderate MDM	**30**
99310	Subsequent nursing facility care, per day, high MDM	**45**

Practice Expense
The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Evaluation and Management

Nursing Facility Services

The following codes are used to report evaluation and management services to patients in nursing facilities and skilled nursing facilities ~~(formerly called skilled nursing facilities [SNFs], intermediate care facilities [ICFs], or long-term care facilities [LTCFs])~~. These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center and intermediate care facility for individuals with intellectual disabilities. ~~(a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.~~

~~Nursing facilities that provide convalescent, rehabilitative, or long-term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs trigger the identification of potential problems and provide guidelines for follow-up assessments.~~

Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visits.

These services are performed by the principal physician(s) and other qualified health care professional(s), overseeing the care of the patient in the facility. The principal physician is sometimes referred to as the admitting physician and is the physician who oversees the patient's care as compared to other physicians or other qualified health care professionals who may be furnishing specialty care. These services are also performed by physicians or other qualified health care professionals in the role of a specialist performing a consultation or concurrent care. Modifiers may be required to identify the role of the individual performing the service.

~~Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning. This role includes providing input in the development of the MDS and a multi-disciplinary plan of care, as required by regulations pertaining to the care of nursing facility residents.~~

Two major subcategories of nursing facility services are recognized: Initial Nursing Facility Care and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients.

The types of care (eg, skilled nursing facility and nursing facility care) are reported with the same codes. Place of service codes should be reported to specify the type of facility (and care) where the service(s) are performed.

*For definitions of commonly used terms, see **Evaluation and Management Services Guidelines.***

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When selecting a level of medical decision making (MDM) for nursing facility services, the Nature and Complexity of Problems Addressed at the Encounter is considered. For this determination, a high level MDM type specific to Initial Nursing Facility Care by the principal physician or other qualified health care professional is recognized. This type is:

Multiple morbidities requiring intensive management: A set of conditions, syndromes or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

The definitions and requirements related to the Amount and Complexity of Data to be Reviewed and Analyzed and the Risk of Complications and/or Morbidity or Mortality of Patient Management are unchanged.

~~(For care plan oversight services provided to nursing facility residents, see 99379-99380)~~

Initial Nursing Facility Care
New or Established Patient

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, office), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same date. ~~all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.~~

In the case when services in a separate site are reported and the initial nursing facility care service is a consultation service by the same physician or other qualified health care professional and reported on the same date, do not report 99304, 99305, 99306, 99252, 99253, 99254, 99255. The consultant reports the subsequent nursing facility care codes 99307, 99308, 99309, 99310 for the second service on the same date.

Hospital inpatient ~~discharge~~ or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient or observation status on the same date of nursing facility admission or readmission, the hospital or observation discharge services ~~should~~ may be reported with codes 99238, 99239 as appropriate. ~~For a patient discharged from observation status on the same date of nursing facility admission or readmission, the observation care discharge services should be reported with code 99217.~~ For a patient admitted and discharged from observation or inpatient status on the same date, see codes 99234- 99236. Time related to ~~these~~ hospital inpatient or observation care services may not be used for code selection of any nursing facility service.

~~(For nursing facility care discharge, see 99315, 99316)~~

Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional. Skilled nursing facility initial comprehensive visits must be performed by a physician. Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide

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timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310).

Initial services by other physicians and other qualified health care professionals who are performing consultations may be reported using initial nursing facility care codes (99304, 99305, 99306) or inpatient consultations (99252, 99253, 99254, 99255). This is not dependent upon the principal care professionals completion of the initial comprehensive services first.

An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses or physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician. An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines.

For reporting initial nursing facility care, transitions between skilled nursing facility level of care ad nursing facility level of care do not constitute a new stay.

~~***Coding Tip***~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code from This Section**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/ floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~

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▲99304	I1	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~these 3 key components:~~ ~~• **A detailed or comprehensive history;**~~ ~~• **A detailed or comprehensive examination; and**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	XXX	1.50
▲99305	I2	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	XXX	2.50

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▲99306	I3	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)	XXX	3.50
Subsequent Nursing Facility Care ~~All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician or other qualified health care professional.~~				
▲99307	I4	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused interval history;**~~ • ~~**A problem focused examination;**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	XXX	0.70

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▲99308	I5	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	XXX	1.30
▲99309	I6	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of moderate complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	XXX	1.92

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▲99310	I7	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of high complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)	XXX	2.80
Nursing Facility Discharge Services The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. These services require a face-to-face encounter ~~but~~ that may be performed on a calendar date prior to the actual discharge date. The time of the face-to-face encounter performed on a date prior to the discharge date is counted toward 99315, 99316 and not reported separately.				
(f)99315	I8	*Nursing facility discharge day management; 30 minutes or less*	XXX	Tabled until October 2021 RUC Meeting
(f)99316	I9	*more than 30 minutes*	XXX	Tabled until October 2021 RUC Meeting

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Other Nursing Facility Services				
~~D99318~~	-	~~Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making that is of low to moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.~~ ~~(Do not report 99318 on the same date of service as nursing facility services codes 99304-99316)~~ (99318 has been deleted. To report, see 99307, 99308, 99309, 99310)	~~XXX~~	~~N/A~~ (2021 work RVU = 1.71)

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CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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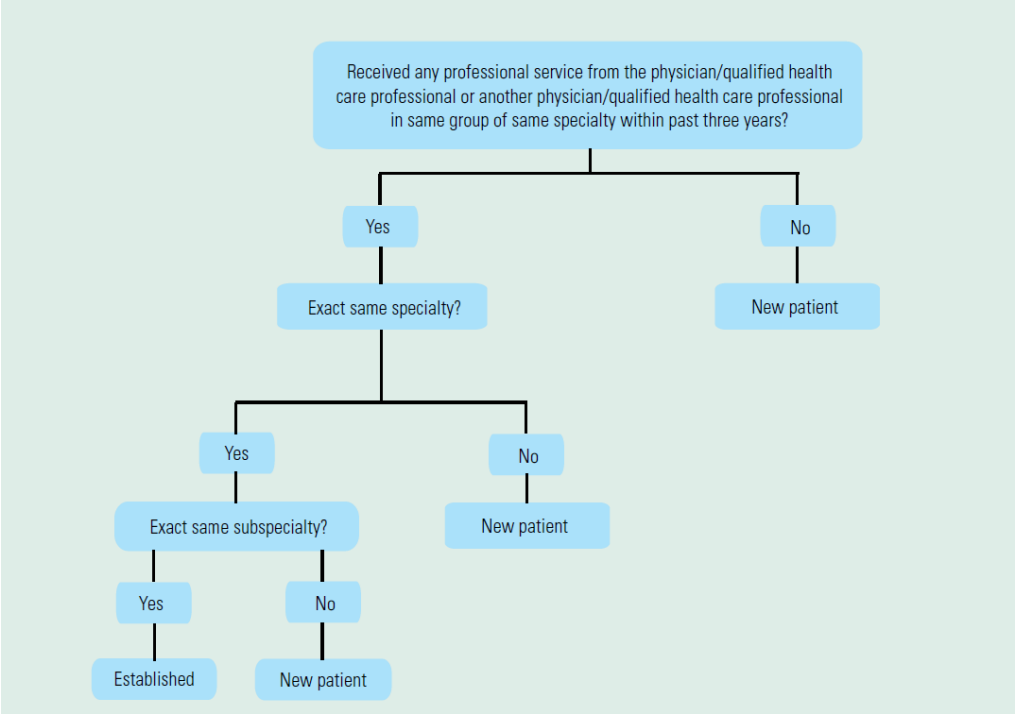
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99304 Tracking Number I1 Original Specialty Recommended RVU: **1.60**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.64** RUC Recommended RVU: **1.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see patient; review medical records, and communicate with other health professionals as necessary.

Description of Intra-Service Work: Obtain a detailed history and fluid intake and other health conditions from patient's family, assisted living staff, and other health care professionals as necessary. Vital signs are noted. Perform a comprehensive physical examination that includes inspecting skin for pre-ulcerations and ulcerations; evaluating patients oral hygiene; cardiovascular, pulmoary, abdominal and genitourinary (GU) exams for evidence of obstructive urinary retention and fecal impaction; evauating patient's ability to communicate; and assessing safety of patient's gait.

Description of Post-Service Work: Follow up with telehpone calls to the facility regarding diagnostic findings, intraservice coordination and documentation of care, and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decsion maker the preferred intensity of care as it relates to do not resuscitate (DNR) orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99304					
Sample Size:	8275	**Resp N:**	203			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**2.00**	12.00	1150.00	
Survey RVW:	0.50	1.50	**1.70**	2.00	30.00	
Pre-Service Evaluation Time:			**6.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	20.00	**25.00**	30.00	120.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99304	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**6.00**	**0.00**	**6.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78072	XXX	1.60	**RUC Time**	12,267

CPT Descriptor 2 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

Other Reference CPT Code	Global	Work RVU	Time Source
70492	XXX	1.62	**RUC Time**

CPT Descriptor Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 86 **% of respondents:** 42.3 **%**

Number of respondents who choose 2nd Key Reference Code: 46 **% of respondents:** 22.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99304	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99202**
Median Pre-Service Time	6.00	5.00	2.00
Median Intra-Service Time	25.00	25.00	15.00
Median Immediate Post-service Time	5.00	5.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**36.00**	**35.00**	**20.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	44%	48%	5%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	48%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	71%	26%
Physical effort required	2%	59%	39%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	40%	53%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	52%	39%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	48%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	67%	29%
Physical effort required	7%	50%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	52%	48%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The expert panel reviewed the initial visit code 99304.

99304 requires straightforward or low-level medical decision making or is based on total time spent on the date of the encounter. There were 203 respondents of whom 79% found the vignette to be typical. The survey times and median work RVU were 6/25/5/36/1.70. The 25th percentile work RVU was 1.5. The key reference services were 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/25/5/35/1.6, and 99202, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 2/15/3/20/0.93.

The expert panel reviewed the current times and work RVU for 99304, 10/23/10/43/1.64.

The panel agreed that while the survey median intra-service time was two minutes higher than the current intra-service time, the total time has decreased by seven minutes. In addition, the survey median intra-service time and total time were practically identical to 99203, the most commonly chosen reference service. Based on the survey times, the expert panel determined a crosswalk to the key reference service, 99203 would result in the most accurate valuation. Therefore, the expert panel recommends for 99304, times and work RVU of 6/25/5/36/1.60.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70

99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99304

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Podiatry How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 449940
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for private and self-pay patients.

Specialty Podiatry Frequency 102586 Percentage 22.79 %

Specialty Family medicine Frequency 82789 Percentage 18.40 %

Specialty Internal Medicine Frequency 56242 Percentage 12.49 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 336,776 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database

Specialty Podiatry Frequency 76785 Percentage 22.80 %

Specialty Family Medicine Frequency 61967 Percentage 18.40 %

Specialty Internal Medicine Frequency 42097 Percentage 12.50 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99304

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99305 Tracking Number I2 Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: XXX Current Work RVU: **2.35** RUC Recommended RVU: **2.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records, laboratory results, and diagnostic findings. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive patient history and perform a comprehensive physical examination. Review patient's intake and hydration status, postoperative condition, initial rehabilitation results, and status of recent urosepsis and pressure ulcer. Evaluate status of patient's multiple chronic health problems. Examine patient's vision and hearing and neurological examination. Develop a multidisciplinary plan of care that includes physical therapy (PT) and occupational therapy (OT) services, initiation of a pressure wound care program, adjustments in diet, weaning off catheter, re-titration of medications, evaluation of dietary and fluid intake, and monitoring for mental status changes due to changes in environment.

Description of Post-Service Work: Follow up with telephone calls to patient's orthopedist and to SNF facility regarding diagnotic findings, post-service coordination and documentation of care, and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decision maker the preferred intensity of care as it relates to DNR orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99305					
Sample Size:	5903	**Resp N:**	204			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**21.00**	82.00	962.00	
Survey RVW:	0.75	2.50	**2.75**	3.00	4.75	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	6.00	25.00	**35.00**	45.00	180.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99305	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-49 mintues of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selction, 30-44 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-49 mintues of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	272,131

CPT Descriptor 2 Polysomnography; age 6 or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
75574	XXX	2.40	**RUC Time**

CPT Descriptor Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 108 **% of respondents:** 52.9 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 12.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99305	**Top Key Reference CPT Code:** 99204	**2nd Key Reference CPT Code:** **99203**
Median Pre-Service Time	10.00	10.00	5.00
Median Intra-Service Time	35.00	40.00	25.00
Median Immediate Post-service Time	10.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**55.00**	**60.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	24%	57%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	31%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	54%	43%
Physical effort required	3%	51%	46%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	27%	70%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	36%	44%	16%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	48%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	72%	20%
Physical effort required	0%	56%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	36%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

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Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

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After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review
The panel reviewed 99305.

99305, requires moderate level medical decision making or is based on total time spent on the date of the encounter. There were 204 respondents of whom 90% found the vignette to be typical. The survey times and median work RVU were 10/35/10/55/2.75. The 25th percentile work RVU was 2.50. The key reference services were 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/40/10/60/2.60, and 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/25/5/35/1.6.

The expert panel noted that the current times and work RVU for 99305 are 11/33/13/57/2.35.

The panel agreed that the increased patient acuity in the nursing facility setting and the shortened length of stay in acute care hospitals before patients are discharged into the nursing home setting supported the survey 25th percentile work RVU of 2.50 and the times of 10/35/10/55/ The panel reviewed the data for the key reference services and agreed that 99202 describes a patient population that is significantly less acute and complex then the patient population described by 99305. The expert panel also agreed that a work RVU of 2.50 placed 99305 in proper rank order with 99204 which has a work RVU of 2.60, a total time of 60 minutes and an intra-time of 40 minutes.

Therefore, the panel recommends times and work RVU of 10/35/10/55/ 2.50

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99305

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes
Specialty Nurse Practitioner	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1333571
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volument and Medicaid volume plus an additional 10% estimated for private payors

Specialty Internal Medicine	Frequency 397404	Percentage 29.79 %
Specialty Family Medicine	Frequency 257379	Percentage 19.29 %
Specialty Nurse Practitioner	Frequency 184033	Percentage 13.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,054,727 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC database

Specialty Internal Medicine	Frequency 314309	Percentage 29.80 %
Specialty Family Medicine	Frequency 203562	Percentage 19.29 %
Specialty Nurse Practitioner	Frequency 145552	Percentage 13.79 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99305

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99306 Tracking Number I3 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: XXX Current Work RVU: **3.06** RUC Recommended RVU: **3.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient with multiple morbidities requiring intensive management

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records, laboratory results, and diagnostic findings. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive history and perform a comprehensive physical examination. Review patient's intake and hydration status and sliding scare insulin and psychotropic regimen. Discuss patient's multiple, still unstable, health problems with health care providers. Assess current status of cardiopilmonary function, swallowing and mobility function, and cognitive function. Review laboratory test findings including oxygenation, hydration, white blood cell count (WBC), cardiac rhythm, and glucose level trends. Initiate orders for O2, IV fluids, antibiotics, pain control, rehabilitation, and diagnostic testing to assess status. Develop a multidisciplinary care plan that includes PT, respiratory therapy (RT), and speech services; titration off insulin sliding scale; adjustments in diet and hydration; re-titration of psychotropic and analgesic medications; and monitoring for mental status changes.

Description of Post-Service Work: Follow up with telephone calls to the facility regarding diagnostic findings and intraservice coordination and documentation of care. Interact with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decision maker the preferred intensity of care as it relates to DNR orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99306					
Sample Size:	5903	**Resp N:**	208			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**50.00**	150.00	1500.00	
Survey RVW:	1.00	3.50	**3.75**	4.00	5.90	
Pre-Service Evaluation Time:			**15.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	9.00	35.00	**50.00**	65.00	340.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99306	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99496	XXX	3.79	**RUC Time**

CPT Descriptor Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical Decision making of high complexity during the service period face-to-face visits, within 7 calendar days of discharge.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90962	XXX	3.57	**RUC Time**	213,048

CPT Descriptor 2 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified helath care professional per month

Other Reference CPT Code	Global	Work RVU	Time Source
50328	XXX	3.50	**RUC Time**

CPT Descriptor Backbench reconstruction of cadavar or living donor renal alograft prior to transplant; atrial anastomosis, each

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 129 **% of respondents:** 62.0 **%**

Number of respondents who choose 2nd Key Reference Code: 30 **% of respondents:** 14.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 99306	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99496**
Median Pre-Service Time	15.00	14.00	0.00
Median Intra-Service Time	50.00	59.00	60.00
Median Immediate Post-service Time	15.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**80.00**	**88.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	12%	36%	50%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	16%	81%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	38%	60%
Physical effort required	2%	44%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	1%	14%	85%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	0%	17%	33%	47%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	27%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	40%	53%
Physical effort required	3%	43%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	10%	83%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

Next, the panel reviewed 99306 which requires a high level of medical decision making or is based on the total time spent on the date of the encounter. There were 208 respondents of whom 94% found the vignette to be typical. The survey times and median work RVU were 15/50/15/80/3.75 and the 25th percentile work RVU was 3.50. The two key reference services were, 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and work RVU of 14/59/15/88/3.5 and, 99496, Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge of medical decision making, with times and work RVU of 0/75/0/75/3.79.

The expert panel noted that the current times and work RVU for 99306 were 15/45/20/80/3.06.

The panel noted that while the total time for 99306 remained the same, the intra-service time increased by 5 minutes (more than 10%). The panel also noted that while the total times and intra-service times were less than for 99205, the patient population and acuity supported a work value at least equal to 99205. Further 99496 has a lower total time than 99406 - but a greater intra time. And the survey median of 3.50 places 99306 in proper rank order with 99496. The panel also reviewed MPC code 90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month, which is an MPC code and has times and work RVU of 0/70/0/70/3.57

The expert panel noted that 90962 has less total time than 99306 but more intra-service time and that the survey 25th percentile work RVU for 99306 of 3.50 places it in correct rank order with 90962 and the key reference services.

Therefore, the expert panel recommends times and work RVU of 15/50/15/80/3.50.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very

consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99306

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes
Specialty Nurse Practitioner	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1751100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate is based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors.

Specialty Internal Medicine	Frequency 745969	Percentage 42.60 %
Specialty Family Medicine	Frequency 341464	Percentage 19.49 %
Specialty Nurse Practitioner	Frequency 171608	Percentage 9.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,389,990 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC database

Specialty Internal Medicine	Frequency 592136	Percentage 42.60 %
Specialty Family Medicine	Frequency 271048	Percentage 19.49 %
Specialty Nurse Practitioners	Frequency 136219	Percentage 9.79 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99306

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99307 Tracking Number I4 Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX Current Work RVU: **0.76** RUC Recommended RVU: **0.70**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a self-limited or minor problem.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review records of previously attempted interventions. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain an interval history that reveals ongoing poor dietary intake and urinary incontinence in a patient who cannot participate in pressure relief activities because of cognitive impairment. Perform a focused physical examination that reveals an improving lesion with no peripheral inflammation and no evidence of systemic involvement. As a result, alter patient's topical regimen, order a new nutritional program, and authorize a support surface.

Description of Post-Service Work: Follow-up with telephone calls to the facility

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99307					
Sample Size:	5903	**Resp N:**	196			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	49.00	3000.00	
Survey RVW:	0.18	0.70	**0.80**	1.30	4.00	
Pre-Service Evaluation Time:			**1.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	10.00	**12.00**	15.00	120.00	
Immediate Post Service-Time:	**1.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99307	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**1.00**	**0.00**	**1.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.70	**RUC Time**	10,729,531

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 2 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
62368	XXX	0.67	**RUC Time**

CPT Descriptor Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 130 **% of respondents:** 66.3 **%**

Number of respondents who choose 2nd Key Reference Code: 43 **% of respondents:** 21.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 99307	**Top Key Reference CPT Code:** 99212	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	1.00	2.00	5.00
Median Intra-Service Time	12.00	11.00	20.00
Median Immediate Post-service Time	1.00	3.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**14.00**	**16.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	1%	7%	61%	27%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	58%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	74%	18%
Physical effort required	7%	68%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	60%	35%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	68%	21%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	19%	51%	30%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	67%	19%
Physical effort required	5%	70%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	60%	31%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99307, which requires straightforward medical decision making or is based on total time spent on the date of the encounter. There were 196 respondents of whom 89% found the vignette to be typical. The survey times and median work RVU were 5/10/5/20/0.76 and the 25th percentile work RVU was 0.70. The two key reference services were 99212, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter, with times and work RVU of 2/11/3/0.70, and 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/20/5/30/1.30.

The expert panel noted that the current times and work RVU for 99307 are 5/10/5/20/0.76.

The panel agreed that while the survey intra-service time was two minutes higher than the current time, the total time decreased by six minutes. Furthermore, the survey intra-service time was one minute more than intra-service time for 99212 and the total time was two minutes less. Given the increased acuity of nursing home patients, the expert panel agreed that the 25th percentile work RVU of 0.70 - which is identical to that of 99212 - placed 99307 In proper rank order with 99212. In addition, the work value of 0.70 places 99307 in proper rank order with 99213 which has a total time more than twice the survey total time for 99307, an intra-service time 66% higher than the 99307 survey median and a work RVU 85% higher than the 25th percentile than the survey 25th percentile work RVU for 99307.

Therefore, the expert panel recommends times and work RVU for 99307 of 1/12/1/14/0/70.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99307

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4035247
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 1000741	Percentage 24.79 %
Specialty Internal Medicine	Frequency 823190	Percentage 20.39 %
Specialty Family Medicine	Frequency 702133	Percentage 17.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,372,760 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 medicare data from the RUC Database

Specialty Nurse Practitioner	Frequency 588444	Percentage 24.79 %
Specialty Internal Medicine	Frequency 484043	Percentage 20.39 %
Specialty Family Medicine	Frequency 412860	Percentage 17.39 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99307

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99308 Tracking Number I5 Original Specialty Recommended RVU: **1.30**
Presented Recommended RVU: **1.30**
Global Period: XXX Current Work RVU: **1.16** RUC Recommended RVU: **1.30**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records. Communicate with other facility health care professionals as necessary.

Description of Intra-Service Work: Obtain an expanded history that includes intake and hydration information, discussion of the suprapubic-localized discomfort, muscle spasm, and psychosocial review of patient's coping ability with underlying disease. Perform an expanding physical examination, which reveals no evidence of dehydration, additional gross hematuria, or focal neurological findings, however, increased patient depression is observed. After necessary laboratory tests are ordered, patient is treated for the UTI and started on anti-depression medication.

Description of Post-Service Work: Follow up with telephone calls to the NF regarding titration of anti-depressant. Review confirming diagnostic laboratory data and antibiotic effectiveness. Discuss coordination and documentation of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99308					
Sample Size:	5903	**Resp N:**	214			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	20.00	**100.00**	350.00	6000.00	
Survey RVW:	0.50	1.30	**1.44**	1.85	5.00	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	3.00	15.00	**18.00**	25.00	120.00	
Immediate Post Service-Time:	**4.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99308	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**4.00**	**0.00**	**4.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.70	**RUC Time**	10,729,531

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74170	XXX	1.40	**RUC Time**	107,476

CPT Descriptor 2 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

Other Reference CPT Code	Global	Work RVU	Time Source
74280	XXX	1.26	**RUC Time**

CPT Descriptor Radiologic examination, colon, including scout absominal radiograph(s) and delayed image(s), when performed; double contrast (eg, high density barium and air) study, including glucagon, when administered

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 140 **% of respondents:** 65.4 **%**

Number of respondents who choose 2nd Key Reference Code: 38 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99308	**Top Key Reference CPT Code:** 99213	**2nd Key Reference CPT Code:** **99214**
Median Pre-Service Time	5.00	5.00	7.00
Median Intra-Service Time	18.00	20.00	30.00
Median Immediate Post-service Time	4.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**27.00**	**30.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	1%	47%	44%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	56%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	67%	29%
Physical effort required	4%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	48%	50%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	55%	26%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	42%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	16%	58%	26%
Physical effort required	11%	55%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	50%	45%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99308 which requires low level medical decision making or is based on total time spent on the date of the encounter. There were 214 respondents of whom 95% found the vignette to be typical. The survey times and median work RVU were 5/18/4/27/1.44 with a 25th percentile work RVU of 1.30. The two key reference services were 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/20/5/1.3, and 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVUs of 7/30/10/47/1.92.

The expert panel noted that the current times and work RVU for 99308 are 7/15/9/31/1.16.

The expert panel noted that while the survey median intra-service time was three minutes higher than the current time, the total time was four minutes less than the current time. Moreover, even though the total and intra-service time were slightly less than the comparable times for 99213 (the first key reference service), the increased acuity of nursing home patients supported an equivalent work RVU. Furthermore, the total and intra-service times for 99214 are 74% and 66% higher than the survey times for 99308 which supports a work RVU for 99308 of 1.30 which is 67% of the work value of 99214.

Therefore, the expert panel recommends times and work RVU for 99308 of 5/18/4/27/1.3.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99308

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 15664105
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 5874039	Percentage 37.49 %
Specialty Internal Medicine	Frequency 3461039	Percentage 22.09 %
Specialty Family Medicine	Frequency 2036334	Percentage 13.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,312,117 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database, plus 10% from deleted code 99318.

Specialty Nurse Practitioner	Frequency 4239781	Percentage 37.47 %
Specialty Internal Medicine	Frequency 2499977	Percentage 22.09 %
Specialty Family Medicine	Frequency 1470575	Percentage 12.99 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99308

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99309 Tracking Number I6 Original Specialty Recommended RVU: **1.92**
Presented Recommended RVU: **1.92**
Global Period: XXX Current Work RVU: **1.55** RUC Recommended RVU: **1.92**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management or potential surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review telephonic orders associated with recently reported URI; changes in dietary, bowel, and psychotropic regimens; and treatment of non-infected skin tear. Communicate with facility health care professionals as necessary..

Description of Intra-Service Work: Obtain a detailed interval history of each organ system that has an acute or active medical problem, including review of patient's multiple medications and recent laboratory and diagnostic testing ordered to evaluate patient's comprised respiratory condition. Perform a detailed physical examination and update the nursing plan of care.

Description of Post-Service Work: Evaluate additional diagnostic testing to determine hydration and pulmonary status and further changes in patient's psychotropic regimen. Follow up with telephone calls to facility staff, discussing coordination and documentation of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99309					
Sample Size:	5903	**Resp N:**	217			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	30.00	**100.00**	355.00	2000.00	
Survey RVW:	0.75	1.92	**2.09**	2.60	6.00	
Pre-Service Evaluation Time:			**7.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	20.00	**30.00**	35.00	120.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99309	**Recommended Physician Work RVU: 1.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter..

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter..

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.92	**RUC Time**	106,900,291

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter..

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	3,816

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

Other Reference CPT Code	Global	Work RVU	Time Source
95957	XXX	1.98	**RUC Time**

CPT Descriptor Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 149 **% of respondents:** 68.6 **%**

Number of respondents who choose 2nd Key Reference Code: 34 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99309	Top Key Reference CPT Code: 99214	2nd Key Reference CPT Code: **99215**
Median Pre-Service Time	7.00	5.00	10.00
Median Intra-Service Time	30.00	30.00	45.00
Median Immediate Post-service Time	10.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**47.00**	**45.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	54%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	1%	36%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	51%	47%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	1%	23%	75%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	15%	15%	50%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	32%	59%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	53%	39%
Physical effort required	6%	47%	47%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	21%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

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The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
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The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The expert panel reviewed 99309 which requires a moderate level of medical decision making or is based on the total time spent on the date of the encounter. There were 217 respondents of whom 86% found the vignette to be typical. The times and median work RVU were 7/30/10/47/2.09 and the 25th percentile work RVU was 1.92. The two key reference services were 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVUs of 7/30/10/47/1.92, and 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80.

The panel noted that the current times and work RVU for 99309 are 10/25/10/45/1.55.

The survey median intra time is five minutes longer than the current intra time and the total time is two minutes higher. Furthermore, the survey times and survey 25th percentile work RVU are identical to the times and work RVU for 99214, the key reference services chosen by 149 of the 217 respondents. Because the survey data for 99309 was a direct crosswalk to the key reference service at the 25th percentile the expert panel agreed to recommend the 25th percentile work RVU of 1.92. This also places 99309 in correct rank order to 99215 which has 50% more intra time (45 min. vs. 30 min.) and 49% more total time (70 min. vs. 47 min.) and 2.80 is 46% higher than 1.92.

Therefore, the expert panel recommends for 99309 times and work RVU of 7/30/10/47/1.92.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99309

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 13567069
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 6146335	Percentage 45.30 %
Specialty Internal Medicine	Frequency 2930703	Percentage 21.60 %
Specialty Family Medicine	Frequency 1628168	Percentage 12.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,094,874 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database plus 85% of deleted 99318

Specialty Nurse Practitioner	Frequency 4571968	Percentage 45.28 %
Specialty Internal Medicine	Frequency 2180492	Percentage 21.59 %
Specialty Family Medicine	Frequency 1222384	Percentage 12.10 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99309

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99310 Tracking Number I7 Original Specialty Recommended RVU: **2.80**
Presented Recommended RVU: **2.80**
Global Period: XXX Current Work RVU: **2.35** RUC Recommended RVU: **2.80**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records and previously ordered diagnostic laboratory tests. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive history. Perform a comprehensive physical examination. Formulate a multidisciplinary treatment plan (MDM of moderate-complexity) that includes IV hydration and antibiotic therapy; nursing instructions regarding monitoring of respiratory, mental, functional, and diabetic status; respiratory and physical therapy assessments with treatment as indicated; and further laboratory monitoring to track effectiveness of treatment.

Description of Post-Service Work: Evaluate results of additionally ordered laboratory and diagnostic testing. Follow up with telephone calls to the facility to adjust interventions as indicated. Document coordination of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss end-of-life issues with family members.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99310					
Sample Size:	5903	**Resp N:**	203			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**15.00**	50.00	1500.00	
Survey RVW:	1.00	2.80	**3.00**	3.60	7.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	30.00	**45.00**	55.00	180.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99310	**Recommended Physician Work RVU: 2.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter

Other Reference CPT Code	Global	Work RVU	Time Source
75561	XXX	2.60	**RUC Time**

CPT Descriptor Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 147 **% of respondents:** 72.4 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 9.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99310	**Top Key Reference CPT Code:** 99215	**2nd Key Reference CPT Code:** **99291**
Median Pre-Service Time	10.00	10.00	15.00
Median Intra-Service Time	45.00	45.00	40.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**70.00**	**70.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	1%	21%	31%	47%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	1%	30%	69%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	44%	54%
Physical effort required	1%	45%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	22%	76%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	42%	11%	42%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	32%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	58%	37%
Physical effort required	5%	58%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	32%	68%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

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The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

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After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99310 which requires high level medical decision making or is based on the total time spent on the day of the encounter. There were 203 respondents of whom 86% found the vignette to be typical. The survey times and median work RVU were 10/45/15/70/3.00 and the 25th percentile work RVU was 2.80. The two key reference services were 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80, and 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, with times and work RVU of 15/40/15/70/4.5.

The expert panel noted that the current times and work RVU for 99310 are 15/35/20/70/2.35.

The expert panel noted that the survey intra time was 10 minutes longer than the current intra time even though the total time was the same. In addition, the survey times and 25th percentile RVU were identical to the times and work RVU for 99215 which was chosen as the key reference service by 147 of the 203 respondents. The survey times and 25th percentile work RVU also place 99310 in correct rank order with 99291 because while the times are similar, 99291 is much more intense service which is reflected by the work RVU for 99291 which is 60% higher then the recommended work RVU for 99310.

Therefore, the expert panel recommends for 99310, times and work RVU of 10/45/15/70/2.8.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70

99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99310

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2142752
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 1075661	Percentage 50.19 %
Specialty Internal Medicine	Frequency 402837	Percentage 18.79 %
Specialty Family Medicine	Frequency 227132	Percentage 10.60 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,676,670 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database, plus 5% from deleted code 99318.

Specialty Nurse Practitioner	Frequency 841520	Percentage 50.18 %
Specialty Internal Medicine	Frequency 315046	Percentage 18.78 %
Specialty Family Medicine	Frequency 177727	Percentage 10.59 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99310

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

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Original Study

Thirty-Year Trends in Nursing Home Composition and Quality Since the Passage of the Omnibus Reconciliation Act

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Keywords:
Quality
Nursing Home Reform Act
OBRA 1987
nursing home characteristics

A B S T R A C T

Objective: In 1987, the Omnibus Reconciliation Act (OBRA) called for a dramatic overhaul of the nursing home (NH) quality assurance system. This study examines trends in facility, resident, and quality characteristics since passage of that legislation.
Methods: We conducted univariate analyses of national data on US NHs from 3 sources: (1) the 1985 National Nursing Home Survey (NNHS), (2) the 1992-2015 Online Survey Certification and Reporting (OSCAR) Data, and (3) LTCfocUS data for 2000-2015. We examined changes in NH characteristics, resident composition, and quality.
Setting and participants: US NH facilities and residents between 1985 and 2015.
Results: The proportion of NHs that are Medicare and Medicaid certified, members of chains, and operating not-for-profit has increased over the past 30 years. There have also been reductions in occupancy and increases in the share of residents who are racial or ethnic minorities, admitted for post-acute care, in need of physical assistance with daily activities, primarily supported by Medicare, and diagnosed with a psychiatric condition such as schizophrenia. With regard to NH quality, direct care staffing levels have increased. The proportion of residents physically restrained has decreased dramatically, coupled with changes in inappropriate antipsychotic (chemical restraint) use.
Conclusions and implications: Together with changes in the long-term care market, the NHs of today look very different from NHs 30 years ago. The 30th anniversary of OBRA provides a unique opportunity to reflect, consider what we have learned, and think about the future of this and other sectors of long-term care.
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For more than 30 years, the quality of nursing home (NH) care has been a continuous concern.[1] In 1984, following published reports and concerns about resident abuse, neglect, and a lack of regulation and oversight, Congress asked the Institute of Medicine (IOM) to investigate the quality of NHs and make recommendations for improvement. The resulting report proposed radical NH reforms,[2] many of which were codified by Congress as part of the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

OBRA 1987 created regulations for NHs in an effort to improve the quality of care delivered to residents. OBRA included a minimum set of care standards and rights for people residing in Medicare- and Medicaid-certified NHs. OBRA 1987 had a focus on residents' quality of life and care, expectations for improved or maintained resident health, as well as residents' rights to banking, organized family councils, and freedom from unnecessary physical and chemical restraints. The Act also standardized certification standards and enforcement strategies. As such, OBRA 1987 was an overhaul of the NH industry and marked a new beginning for NH care and regulation.

In the 30+ years since OBRA 1987, there have been a number of other changes that have directly affected the NH industry. In response

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VM is chair, Independent Quality Committee, of HCR Manor Care; is chair, Scientific Advisory Board, and consultant for NaviHealth, Inc; and former director, PointRight, Inc (holds less than 1% equity). The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs, the National Institutes of Health, or the United States government.

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to consumer preferences to remain in the community, "age-in-place," and efforts to rebalance states' long-term care budgets,[3–5] there has been a considerable increase in home- and community-based services (HCBS). HCBS were seen as mechanisms to divert or delay expensive, and often undesired, NH placement. Over the last several decades, states have begun funding more HCBS, primarily through Medicaid waiver programs; and, for the first time in 2013, states spent more on HCBS than care provided in NHs.[6] Accompanying these care delivery, market, and financing changes has been growth of an aging and diversifying population, as well as a number of laws and regulations directly impacting the NH industry (eg, the Balanced Budget Act of 1997 and the introduction of case-mix reimbursement).

The purpose of this study was to summarize changes in the NH industry in the 30 years since the seminal regulatory change affecting NHs. Specifically, we use historical data from 3 national sources and describe changes in NH facility characteristics, resident characteristics, and quality of care from 1985 through 2015. The 30th Anniversary of OBRA provides a unique opportunity to examine the changes within this vitally important industry. This article can aid in understanding long-term trends, as well as provide insight into what changes we might expect in the future.

Methods

Data

We analyzed data from 3 sources to examine resident and facility characteristics, longitudinally: (a) National Nursing Home Survey, (b) Online Survey Certification and Reporting Data/Certification and Survey Provider Enhanced Reporting, and (c) LTCFocUS data.

National Nursing Home Survey (NNHS)

The National Center for Health Statistics conducted the NNHS. The NNHS consists of a nationally representative sample of more than 1,000 NHs and their residents. NHs included in the surveys had at least 3 or more beds and were Medicare or Medicaid certified or had a state license to operate as an NH. The facilities and residents were selected by a stratified 2-stage probability design. In the first stage, NHs were selected, and in the second stage, residents were sampled from the selected NHs. NNHS data were used to describe facility and aggregated resident characteristics. Data for these analyses came from the University of Michigan ICPSR public use NNHS data files for 1985.[7]

Online Survey Certification and Reporting Data (OSCAR)/ Certification and Survey Provider Enhanced Reporting (CASPER)

CMS' OSCAR/CASPER database is a national database of all NH data elements collected by state survey agencies during the required annual onsite Medicare and Medicaid Certification inspection. The inspections occur at least once during a 15-month period. OSCAR/CASPER data are used to determine facility characteristics, deficiencies in care noted during the survey, and aggregated resident data. Data included all certified NHs between the years 1992 and 2015. Variables in OSCAR/CASPER have been validated for research purposes.[8]

Long-Term Care FocUS (LTCFocUS)

We used LTCFocUS.org, a product of the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research and supported, in part, by the National Institute on Aging (www.ltcfocus.org). This data set included information for years 2000-2015 and combined variables from the OSCAR data; the Minimum Data Set (MDS), resident-level data related to resident clinical and functional status; the Area Resource File (ARF), a national county-level health resources database maintained by the Health Resources and Services Administration that contains data about the health professionals and facilities in each county; and the Residential History File, a data resource built using Medicare Enrollment data, Medicare claims data, and assessment data to track individuals as they move through the long-term care system.[9] For these analyses, we used the LTCFocUS data to describe the aggregated characteristics of residents served in NHs between 2000 and 2015.

Variables

We included the following facility characteristics to describe changes in the NH market over time: dual certification for Medicare and Medicaid, multifacility chain membership, for-profit status (vs nonprofit or government), presence of an Alzheimer's special care unit, facility size (ie, total number of beds), and occupancy rate.

To describe the resident composition, we included demographic characteristics, length of stay, admission source, physical function, mental health diagnoses, and medication use measures. Demographic variables from LTCfocUS included the percentage of female residents in each facility; the percentage of blacks, whites, and Hispanics in each facility; and the average age for residents residing in each facility. Also from the LTCfocUS, we included the percentage of long-stay residents, defined as the percentage of residents in the NH at least 90 of the last 100 days. We also include the percentage of residents admitted to the NH directly from the hospital vs the community or other LTC setting. From the OSCAR/CASPER, we included information about residents' primary payer as the percentage of residents whose primary support was Medicaid or Medicare. Measures of resident physical and cognitive function included the facility's average Activities of Daily Living (ADL) scale score, bed/chair bound measures, individual early-, middle-, and late-loss ADL, and the percentage of residents with dementia. The ADL scale score comes from LTCFocUS, ranges from 0 to 28, and is created by summing 7 ADL items on a scale from 0 to 4 (with 0 = complete independence and 4 = total dependence for each item). The facility average represents the average across all residents in the facility. Chairbound and bedbound measures come from the NNHS and OSCAR/CASPER data and refer to the percentage of residents unable to leave their chair or bed, respectively, at the time of the survey. The individual ADL of interest from the NNHS and OSCAR/CASPER data include dressing, bathing, transferring, toileting, and eating, and represent the percentage of residents who were not completely independent in each of these activities at the time of the survey. From the NNHS and OSCAR/CASPER data, we also included a measure for the percentage of residents with dementia within the facility. Measures of resident mental health and medication use included the percentage of residents with a psychiatric diagnosis (excluding dementia and depression), a schizophrenia diagnosis, receiving antianxiety medications, receiving antidepressants, and receiving antipsychotics.

Information on facility quality consisted of structure, process, and outcome measures.[10] As a measure of structure, we included the number of certified nursing aides, licensed professional nurses, and registered nurse hours per resident per day from the OSCAR/CASPER data. We obtained information about facilities' quality process measures including the percentage of residents in a facility who were physically restrained, received tube feeding, had a catheter, received antipsychotic medications without a diagnosis of schizophrenia or bipolar disorder at the time of the survey, and the percentage of facilities experiencing medication errors. Medication error refers to the percentage of facilities cited for drug error rates higher than 5% reported during the annual survey. Quality outcome measures included the percentage of residents within a facility with pressure ulcers, and the percentage of residents within a facility experiencing incontinence. Values for pressure ulcers indicate the percentage of residents during the annual survey with pressure sores. The incontinence measures indicate the percentage of residents with bladder or bowel incontinence at the time of the survey.

Table 1
Changes Over Time in Facility Characteristics (1985-2015)

Year	1985, Mean (CI)	1995, % or Mean (SD)	2005, % or Mean (SD)	2015, % or Mean (SD)
Number of nursing homes, n	19,068*	16,824	16,091	15,686
Percentage dual (Medicare + Medicaid) certified	33.3 (28.9, 37.8)	78.6	93.4	97.1
Percentage member of a chain		51.24	52.43	56.81
Percentage for-profit	75.0 (70.9, 79.1)	66.4	66.0	69.1
Percentage with Alzheimer's Unit		11.2	18.2	15.2
Average number of beds		100.84 (67.93)	104.97 (65.37)	106.13 (61.31)
Percentage with 3-49 beds	33.7 (26.8, 41.0)	18.8	14.9	12.9
Percentage with 50-99 beds	32.4 (28.0, 36.8)	36.0	36.3	37.1
Percentage with 100-199 beds	27.8 (24.2, 31.5)	38.5	42.2	44.0
Percentage with ≥200 beds	6.1 (5.1, 7.2)	6.8	6.5	6.0
Average occupancy rate		87.14 (16.41)	84.43 (15.14)	81.19 (15.79)

CI, confidence interval; SD, standard deviation.
*Weighted number of facilities.
Source: The 1985 National Nursing Home Survey and the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data.

Analyses

Univariate analyses of the above variables were completed using Stata, version 14 (StataCorp, College Station, TX). Data from the NNHS were weighted using the facility, bed, and current resident weights provided. OSCAR/CASPER and LTCFocUS data are available at the facility level. Facility-level variables are averaged for each study year. We do not include inferential statistics in this article because we are presenting data for the entire population of NHs in the United States for the majority of years.

Results

Facility Characteristics

In the past 30 years, the NH industry has decreased in size, from 19,068 facilities in 1985 to 15,686 in 2016 (Table 1). There has also been an increase in the percentage of facilities that are nonprofit (25% in 1985 and 31% in 2015) and that are dually certified by both Medicare and Medicaid (33% in 1985 and up to 97% 2015). Between 1995 and 2015, chain membership increased from 51% to 57%, the percentage of facilities with an Alzheimer's special care unit increased from 11% to 15%, and the overall NH occupancy rates declined from 87% to 81%.

Resident Composition

The population that NHs serve has changed over the last 30 years (Table 2). Data from the NNHS and LTCFocUS suggest that although the average age of residents has remained constant, the percentage of residents who are racial and ethnic minorities has increased from 7.8% in 1985 to 20.7% in 2015. The average percentage of females decreased from 72% of residents in 1985 to 67% in 2015. The prevalence of long-stay residents within NHs has remained stable at 69% of all residents over this time period. However, the percentage of residents admitted from the hospital increased from 67% in 2000 to 85% in 2015. There has also been a shift of payer types over time (Figure 1). Between 1992 and 2015, the average percentage of residents with Medicaid as a primary payer decreased from 64% to 58%, whereas the average percentage of residents with Medicare as the primary payer rose from 9% to 15%.

Resident physical and cognitive function has decreased over the years (Table 3). According to LTCFocUS data, the average ADL dependency score among NH residents increased slightly, from 15 to 17, between 2000 and 2015. According to NNHS and OSCAR/CASPER data, residents who required assistance in bathing increased from a national average of 89% in 1985 to an average facility average of 96% in 2015. The same trend is demonstrated by the increased share of residents who need assistance with the other ADL from 1985 to 2015: assistance with dressing rose from 74% to 92%, assistance with transferring from 60% to 85%, assistance with toileting from 49% to 88%, and assisting with eating increased from 38% to 56%. However, there was a decrease in the percentage of residents who were bed-bound from 6% in 1985 to 4% in 2015, whereas being chair bound rose from 39% to 64%. The percentage of residents with dementia increased from an average of 39% in 1995 to an average of 45% across the facilities in 2015.

The share of residents with psychiatric diagnoses has increased over the years, as has the use of psychotropic medications. According to the OSCAR/CASPER data, there was an almost 3-fold increase in the share of residents with a psychiatric diagnosis, from 11% in 1995 to 31% by 2015. Between 1985 and 2015, the average percentage of

Table 2
Changes Over Time in Resident Demographics, Length of Stay, and Admission Source (1985-2015)

Year	1985, Mean (CI) (n = 1,489,508*)	2000, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Percentage female	71.6 (70.3, 73.0)	72.1 (13.8)	70.9 (14.0)	66.7 (13.04)
Percentage black	7.0 (6.2, 7.8)	9.9 (17.8)	10.9 (18.5)	11.6 (18.0)
Percentage Hispanic	2.8 (2.3, 3.2)	2.9 (9.1)	3.4 (9.8)	4.5 (11.3)
Percentage white	92.2 (91.4, 93.0)	85.6 (21.3)	83.7 (22.6)	79.3 (24.0)
Average age, y	79.61 (79.21, 80)	80.95 (7.11)	80.15 (7.68)	79.71 (7.34)
Percentage long stay		69.3 (22.6)	70.6 (19.3)	68.6 (17.0)
Percentage admitted from the hospital		66.5 (22.9)	72.8 (21.5)	84.7 (17.2)

CI, confidence interval; SD, standard deviation.
NNHS data represent the weighted national averages, whereas LTCFocUS data represent the average of facility averages.
*Weighted number of residents.
Source: The 1985 National Nursing Home Survey(NNHS) and Brown University's LTCFocUS Data for 2000, 2005, and 2015.

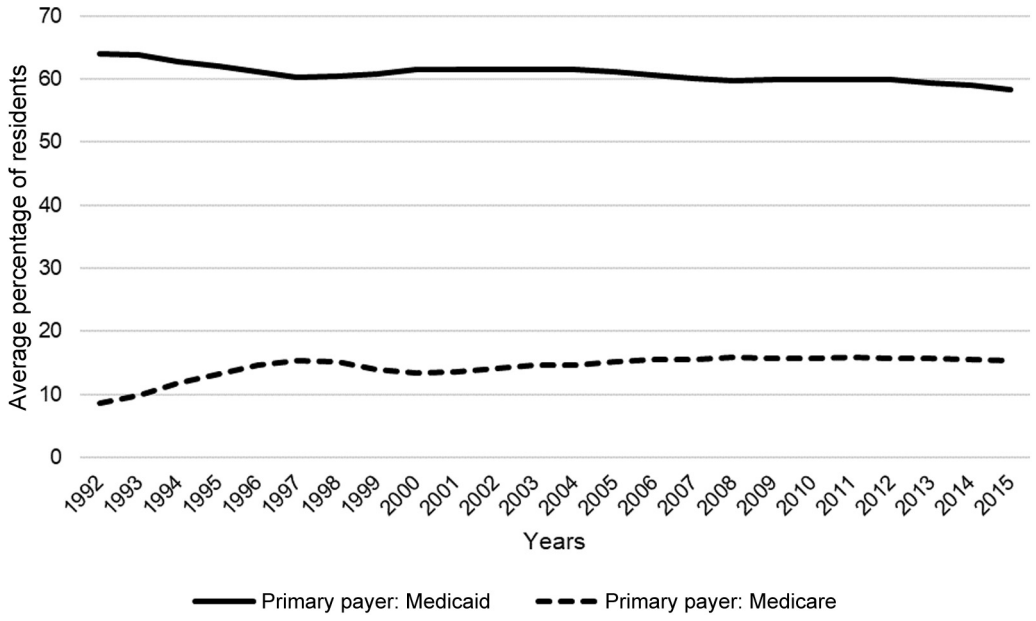

Fig. 1. Primary payment source using OSCAR/CASPER Data (1992-2015).

residents with schizophrenia increased from 6% to 11%. The percentages of residents receiving antianxiety, antidepressant, and antipsychotic medications in 1995 were 15%, 20%, and 16%, respectively, and by 2015 increased to 23%, 49%, and 20%, respectively.

Quality of Care

The average direct care staffing hours have increased over time, with the greatest increases observed among CNAs (see Table 4). Overall, quality process measures have also improved since the passage of OBRA 1987. Notably, the average proportion of residents being physically restrained decreased dramatically from 19% to 1%, and the percentage of residents receiving antipsychotic medications inappropriately, as a chemical restraint, decreased from 16% in 2000 to 12% in 2015, although there was a peak of 22% in 2005. However, there was not much change in the proportion of facilities cited for medication errors over this time period.

Quality outcome measures also improved over time. The proportion of residents with pressure ulcers decreased from 8% to 6%. Lastly, congruent with increased need for assistance, bowel and bladder incontinence increased from 42% to 44% and 49% to 62%, respectively.

Table 3
Changes Over Time in Resident Function, Mental Health, and Medication Use (1985-2015)

Year	1985, % (CI) (n = 1,489,508)*	1995/2000†, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Physical and cognitive function				
Average Activities of Daily Living (ADL) Scale score†		15.26 (3.47)	15.60 (3.32)	16.87 (2.62)
Percentage of residents bed bound	6.5 (5.8, 7.2)	6.6 (9.9)	4.3 (7.4)	3.7 (6.9)
Percentage of residents chair bound	39.5 (38.1, 40.9)	48.1 (21.3)	55.1 (21.2)	64.3 (21.4)
Percentage of residents needing assistance with early-loss ADL				
Dressing	74.2 (72.8, 75.5)	86.6 (12.4)	88.2 (11.7)	91.8 (10.9)
Bathing	89.2 (88.1, 90.2)	94.2 (10.1)	95.4 (9.2)	96.5 (8.5)
Percentage of residents needing assistance with middle-loss ADL				
Transfer	60.2 (58.8, 61.7)	72.7 (16.5)	77.3 (15.4)	85.5 (14.7)
Toileting	49.2 (47.7, 50.6)	76.6 (15.0)	81.5 (13.9)	88.1 (13.0)
Percentage of residents needing assistance with late-loss ADL				
Eating	37.7 (36.3, 39.1)	53.0 (22.2)	49.4 (21.9)	56.5 (28.9)
Percentage of residents with dementia	43.3 (41.9, 44.8)	39.0 (20.0)	45.2 (19.4)	45.3 (18.4)
Mental health and medication use				
Percentage of residents with psychiatric diagnosis		11.2 (13.9)	19.8 (17.2)	31.4 (19.5)
Percentage of residents with schizophrenia†	5.7 (5.0, 6.4)	6.1 (9.9)	7.7 (11.0)	10.4 (13.0)
Percentage of residents receiving antianxiety medications		14.6 (10.2)	17.6 (10.3)	23.0 (11.6)
Percentage of residents receiving antidepressant medications		19.5 (10.9)	45.8 (14.3)	48.7 (14.5)
Percentage of residents receiving antipsychotic medication		16.0 (13.1)	26.0 (14.7)	20.1 (14.5)

CI, confidence interval; SD, standard deviation.
NNHS data represent the national averages, whereas OSCAR data represent the average of facility averages. The average ADL score is based on 7 ADL ranges from 0 to 28, where 0 = total independence and 28 = total dependence. The Average Acuity Index includes ADL and special treatment measures.[9]
*Weighted number of residents.
†These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER data.
Source: The 1985 National Nursing Home Survey (NNHS), the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data(OSCAR/CASPER), and the Brown University's LTCFocUS Data for 2000, 2005, and 2015.

Table 4
Changes Over Time in Quality Indicators (1995-2015)

Year	1995/2000*, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Structure (staffing)			
CNA hours per resident day	2.26 (1.73)	2.30 (1.15)	2.42 (1.05)
LPN hours per resident day	0.87 (1.49)	0.84 (0.81)	0.88 (0.73)
RN hours per resident day	0.66 (1.64)	0.45 (0.86)	0.58 (0.87)
Direct care hours per resident day	3.39 (2.08)	3.48 (1.56)	3.79 (1.42)
Process			
Percentage of residents restrained	18.6 (17.2)	6.9 (8.7)	1.4 (4.9)
Percentage of residents receiving tube feeding	6.3 (8.5)	6.0 (8.4)	4.7 (8.2)
Percentage of residents with a catheter	8.3 (9.5)	7.0 (7.0)	5.9 (5.3)
Percentage of residents receiving inappropriate antipsychotic medication*	16.4 (9.4)	21.9 (10.2)	12.4 (7.6)
Percentage of facilities cited for medication errors ≥5%	1.5	1.8	1.7
Outcome			
Percentage of residents with pressure ulcers	7.6 (8.0)	7.4 (6.0)	6.2 (5.1)
Percentage of residents with bowel incontinence	41.8 (19.1)	42.9 (18.0)	43.9 (18.4)
Percentage of residents with bladder incontinence	49.3 (18.5)	53.5 (17.4)	62.1 (18.2)

CNA, certified nursing aide; LPN, licensed professional nurse; RN, registered nurse; SD, standard deviation.
*These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER Data.
Source: The 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data (OSCAR/CASPER), and the 2000, 2005, and 2015 Brown University LTCFocUS Data.

Discussion

Within this 30-year period, there were facility, resident, and quality of care changes that can be linked to regulations adopted through the OBRA 1987 and other policy shifts in the long-term care sector.

Certification

Over the last 30 years, we witnessed a change in NH certification. This change is consistent with the OBRA 1987 requirement for NHs to be certified and meet the federal participation requirements in order to receive Medicaid and Medicare payments.[11] Previously, Medicare-certified facilities had more stringent requirements, but seeing that the majority of government spending came from Medicaid, OBRA 1987 stipulated that all Medicaid-certified facilities met a set of standards that were similar to that of Medicare.[1] Additionally, noting Medicare's generous reimbursement for skilled care, many Medicaid-only NHs became dually certified in both Medicare and Medicaid.[12] These policy and financing incentives likely contributed to the increase in the proportion of facilities that were dually certified during this time period.

Changing Demand and Supply, and Lower Occupancy

Concurrent with shifting US demographics (eg, an aging and increasingly diverse population), NHs in the last 30 years have witnessed increases in the proportion of minorities and decreases in the proportion of white residents. Recognizing the aging population, the long-term care market began to appear more lucrative and attracted a greater number of investors to NH operations.[13] This is evidenced by the percentage of NHs that were owned and operated by a chain. Stevenson, Grabowski, and Coots (2006) posit that chain facilities increased because of the interplay of certificate of need laws and resulting acquisitions.

Despite the aging of the population, there was a decrease in the number of NHs and facility occupancy rates during this time period. This decrease in NH supply and occupancy is likely attributable to the rise of community options such as assisted living and other HCBS.[14,15] In 2000, Medicaid spent about 27% of its total Medicaid long-term services and supports expenditures on HCBS and 73% on institutional care; by 2016, 57% of the expenditures were for HCBS and 43% for NH care.[6] It can be difficult to quantify the increase in community-based services due to data challenges; however, the National Survey of Resident Care Facilities identified approximately 31,100 residential facilities in 2010 and researchers have suggested a continued growth in the market.[16–18] The growth of long-term care alternatives allows individuals to remain in their homes and communities longer, in many cases delaying NH placement or diverting it altogether.[19–23] These trends may also explain some of the reasons behind the increase in functional impairment among NH residents over this time period.

Another potential explanation for the increase in functional impairment witnessed over this 30-year period may be the increase in post-acute, rehabilitative care provided in NHs. Recognizing the profitability associated with providing Medicare-reimbursed services,[24] NHs began to accept more post-acute care patients, with a large number of NHs choosing to specialize in the care of post-acute patients.[12,25] This shift in the orientation of NHs over this time period, from providing typically long-term custodial care to post-acute, rehabilitative care, may contribute to the increase in resident acuity witnessed in this study. It is evident from our findings that there is an increased percentage of residents being admitted directly from the hospital, presumably for post-acute care, which may contribute to higher levels of functional impairment as residents may be leaving hospitals "quicker and sicker."[26,27]

Quality Improvement

Despite higher resident levels of need, NH quality appears to have improved over time. Our data show modest gains in quality indicators between 1995 and 2015. The literature around drivers of quality improvement in NHs is vast and includes mechanisms such as NH ownership, nurse staffing, public reporting, and quality improvement initiatives. The quality improvement that we witnessed during this time period could have been attributable to the increase in nonprofit NHs, which have consistently shown to have higher quality ratings.[13] Quality improvement could also be directly related to the increase in nursing hours witnessed over this time period. OBRA 1987 improved the standards for nursing hours, and we observed these increases over time. Although it is possible that the increase in nursing hours may be in direct response to increasing need among residents, prior research has concluded that increasing nursing hours improves patient outcomes.[28–30] It is also plausible that new inspection, survey, enforcement efforts, and public reporting prompted improvements in quality

measures.[1,31] Although it can be argued that NHs still have room to improve in their quality indicators, it is important to note that despite an increasingly vulnerable and higher need population, we still observe quality gains among NHs during this time period.

One of the direct effects of OBRA 1987 was a substantial decrease in the use of physical restraints. Physical restraints were initially used on residents with serious mental illness to manage behaviors, but began to be used more widely on residents with behavioral symptoms, including residents with dementia.[32] Prior research indicates that physical restraints are associated with worse outcomes for residents, such as increased depression, less social engagement among NH residents,[33–35] reduced muscle strength,[33] and pressure ulcers.[33,34,36] Parts of OBRA 1987 focused directly on the residents' rights to be free from all restraints. Unfortunately, decreases in physical restraints were coupled with initial increases in chemical restraint use, such as inappropriate antipsychotic use. Antipsychotic medications increase the risk of falls[37] and death.[38,39] In 2005, the FDA released a Black Box warning to decrease the use of antipsychotics among older adults.[40] This warning is consistent with the 2005 peak in antipsychotic use that is present in our data. In 2011, CMS launched a national partnership to further reduce inappropriate antipsychotic use, which has been largely successful.[41] With the increase in dementia residents and initiatives to improve dementia care in NHs, there was a simultaneous increase in Alzheimer's SCUs, with a peak in the percentage of facilities with an Alzheimer's SCU in 2005. Literature suggests that residents within facilities with SCUs have significantly more challenging behaviors and have increased risk for chemical restraint use.[42,43] The presence of these units may also account for the increased resident impairment.

It is also important to note the dramatic increase in residents with serious mental illnesses (SMI), as this could be a direct result of state psychiatric facilities closures in the 1960s and 1970s. The increase in the SMI population creates a new and increased burden for NHs and their staff that may negatively affect the quality of care that NHs are able to provide.[44,45]

Despite the success of several prompted voiding interventions,[46,47] we observed increases into the share of NH residents experiencing incontinence over the past 30 years, potentially reflective of the increasing needs of the NH population. Prompting toileting interventions can be labor intensive, and it is often more convenient to diaper a resident than toilet.[48] More work is needed in this important quality of life area.

Limitations

This work provides a high-level look at national trends in NH characteristics, resident composition, and quality measures. Data are averaged across all facilities for the available study years. We do not have access to annual data available between 1986 and 1994, and because of the facility-level nature of our data we are unable to summarize resident-level changes over time. For example, it would be interesting to examine changes in acuity, separately for long-stay vs short-stay residents, or changes in residents' lengths of stay. This would help us understand if the increase in acuity over time is due to an increased focus on post-acute care, or attributable to higher levels of acuity among long-term residents who may delay entry into NHs through home- and community-based alternatives. Future work in this area would be beneficial to understanding additional impacts of OBRA on the long-term care industry as a whole.

Conclusions and Implications

Overall, OBRA 1987 is positively associated with the quality of care improvements in NHs despite increasing impairment of NH residents. OBRA 1987 was also successful in implementing and enforcing the MDS resident assessment survey, and without that this research would not be possible. Because of the aging-in-place movement, we are seeing lower occupancy rates in NHs. Older adults without financial resources, disproportionality minority older adults, are becoming an increasing proportion of NH residents, as they may not be able to as readily access these care alternatives. Current and future policies should focus on expanding equitable access to the remaining long-term care services and supports in the continuum of care, particularly given the policies and initiatives focused on decreasing NH utilization through support of home and community based alternatives.[49] Although NHs continue to focus more on short-stay post-acute care residents and long-stay residents with dementia, more work will need to be done in community-based settings to ensure the highest quality care and life. Improving quality is also about improving equity, and it is important for future work to examine access to quality care for our most vulnerable older adults who are sometimes triply and doubly vulnerable because of their cognitive status, race, and/or socioeconomic position. As our work shows, much of the quality progress made in NHs has been because of regulation and oversight over the years. The same level of oversight does not exist for all community alternatives, but the evidence presented here is indicative of effective practices.

Future research is also needed to understand whether these improvements in quality over the past 30 years have been equitable on the basis of race, socioeconomic status, gender, and geography. In sum, our findings document the 30-year history of NHs since the passage of the seminal legislation: OBRA 1987. As we look toward the future of long-term care, it is important that we reflect on the past.

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Hospital Transfer Rates Among US Nursing Home Residents With Advanced Illness Before and After Initiatives to Reduce Hospitalizations

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IMPORTANCE Hospital transfers among nursing home residents in the United States who have been diagnosed with advanced illnesses and have limited life expectancy are often burdensome, costly, and of little clinical benefit. National initiatives, introduced since 2012, have focused on reducing such hospitalizations, but little is known about the consequences of these initiatives in this population.

OBJECTIVE To investigate the change in hospital transfer rates among nursing home residents with advanced illnesses, such as dementia, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD), from 2011 to 2017—before and after the introduction of national initiatives to reduce hospitalizations.

DESIGN, SETTING, AND PARTICIPANTS In this cross-sectional study, nationwide Minimum Data Set (MDS) assessments from January 1, 2011, to December 31, 2016 (with the follow-up for transfer rates until December 31, 2017), were used to identify annual inception cohorts of long-stay (>100 days) nursing home residents who had recently progressed to the advanced stages of dementia, CHF, or COPD. The data were analyzed from October 24, 2018, to October 3, 2019.

MAIN OUTCOMES AND MEASURES The number of hospital transfers (hospitalizations, observation stays, and emergency department visits) per person-year alive was calculated from the MDS assessment from the date when residents first met the criteria for advanced illness up to 12 months afterward using Medicare claims from 2011 to 2017. Transfer rates for all causes, potentially avoidable conditions (sepsis, pneumonia, dehydration, urinary tract infections, CHF, and COPD), and serious bone fractures (pelvis, hip, wrist, ankle, and long bones of arms or legs) were investigated. Hospice enrollment and mortality were also ascertained.

RESULTS The proportions of residents in the 2011 and 2016 cohorts who underwent any hospital transfer were 56.1% and 45.4% of those with advanced dementia, 77.6% and 69.5% of those with CHF, and 76.2% and 67.2% of those with COPD. The mean (SD) number of transfers per person-year alive for potentially avoidable conditions was higher in the 2011 cohort vs 2016 cohort: advanced dementia, 2.4 (14.0) vs 1.6 (11.2) (adjusted risk ratio [aRR], 0.73; 95% CI, 0.65-0.81); CHF, 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81); and COPD, 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72). Transfers for bone fractures remained unchanged, and mortality did not increase. Hospice enrollment was low across all illness groups and years (range, 23%-30%).

CONCLUSIONS AND RELEVANCE The findings of this study suggest that concurrent with new initiatives aimed at reducing hospitalizations, hospital transfers declined between 2011 and 2017 among nursing home residents with advanced illnesses without increased mortality rates. Opportunities remain to further reduce unnecessary hospital transfers in this population and improve goal-directed care for those residents who opt to forgo hospitalization.

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Supplemental content

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A central objective of the Patient Protection and Affordable Care Act (ACA) of 2010 was to transform health care by ensuring that patients receive high-value, effective care.[1] Toward this objective, there has been particular focus on reducing potentially avoidable hospital transfers from the long-term care setting. The opportunity and need to reduce avoidable hospitalizations are greatest among people with advanced chronic illnesses[2] for whom the burdens of hospitalization often outweigh the benefits.[3-5] Little is currently known about how hospital transfer rates have changed among this population since broad initiatives were introduced.

Approximately 50% of nursing home residents experience 1 or more hospitalization in their last year of life.[6] At least half of these hospitalizations are estimated to be potentially avoidable because the acute condition could be managed effectively in the nursing home or the hospital-level care is not aligned with patient preferences.[7-11] Decisions regarding hospital transfers should be guided by the primary goal of care (eg, prolongation of life vs comfort), which is comfort for most nursing home residents with advanced illness.[12-15] With rare exceptions (eg, serious bone fractures), hospitalization seldom promotes the goal of comfort.

Since 2012, several new approaches have emerged from the ACA to try to reduce hospital transfers of nursing home residents. Care models that enhance the nursing home's on-site capability to manage specific targeted conditions (sepsis, pneumonia, urinary tract infections, dehydration, congestive heart failure [CHF], and chronic obstructive pulmonary disease [COPD]) have shown promise through the quality initiative program of the Centers for Medicare & Medicaid Services (CMS) to reduce avoidable hospitalizations.[9,10] Evaluation of the initiative's first phase in 7 states demonstrated estimated net reductions in 2015 of 2.2% to 9.3% in the probability of an all-cause hospitalization and 1.4% to 7.2% in the probability of a potentially avoidable hospitalization for participating residents compared with comparison groups.[1] Alternative payment models, such as accountable care organizations and bundled payments, also create financial incentives for nursing homes to reduce hospital transfers.[16] The Hospital Readmissions Reduction Program (HRRP) implemented financial penalties for hospitals with excess readmissions for target conditions including pneumonia, CHF, and COPD.[17,18] These concurrent initiatives raised national awareness and forged collaborations around transitional care to avoid unnecessary hospitalizations.[19] The consequences of such initiatives on hospital transfer rates, specifically among residents with advanced illnesses, have not been reported, to our knowledge.

The present study used Minimum Data Set (MDS) assessments linked to Medicare data to examine the national trends of hospital transfer rates from 2011 to 2017 among long-stay, fee-for-service nursing home residents with advanced dementia, CHF, or COPD. We specifically examined transfers for conditions that were deemed to be potentially avoidable and were the target of recent policy initiatives. For comparison, we also examined hospital transfer rates for serious bone fractures, which we hypothesized would be less affected by such initiatives. Finally, we assessed mortality and hospice enrollment rates.

Key Points

Question How did the hospital transfer rates change between 2011 and 2017 among nursing home residents diagnosed with advanced illness and limited life expectancy before and after the introduction of national initiatives to reduce hospitalizations?

Findings In this US nationwide cross-sectional study of 6 cohorts of nursing home residents with advanced illness, such as dementia, congestive heart failure, and chronic obstructive pulmonary disease, although hospital transfers for all causes and for potentially avoidable conditions were common, such transfers were found to have declined considerably from 2011 to 2017, and concurrent hospice use was low across all cohorts.

Meaning The findings of this study suggest that hospital transfer rates among nursing home residents with advanced illness declined from 2011 to 2017 and that opportunities remain to reduce unnecessary hospital transfers among residents with advanced illness.

Methods

Advanced Illness Cohorts

In this cross-sectional study, the MDS version 3.0 assessments[20] from federally licensed nursing homes in the United States were used from January 1, 2011, to December 31, 2016, to construct annual inception cohorts of long-stay residents (ie, >100 days) aged 65 years or older who were diagnosed with advanced dementia, CHF, or COPD. The MDS version 3.0 is a standardized, comprehensive assessment conducted on all nursing home residents at admission and at routine intervals (eg, quarterly) and was implemented in 2011.[20] Key differences between MDS 3.0 and MDS 2.0 precluded us from using MDS before 2011.[21] To construct these cohorts, we identified residents from the first MDS assessment at which they met the full criteria for advanced dementia, CHF, or COPD (hereafter, baseline assessment) in each calendar year. Residents may have had the illness, such as CHF, on a prior MDS assessment but were not included in the cohort until they first met the criteria for advanced disease, as described below. Residents had to be continuously enrolled in the Medicare Parts A and B fee-for-service program for up to 12 months after their baseline assessment and could belong to more than 1 advanced illness group. Residents enrolled in hospice at the baseline assessment were excluded. The institutional review board at Brown University approved this study under expedited review and waived informed consent under 45 CFR 46.116.

We defined advanced dementia, CHF, and COPD using criteria adapted from previous studies[5,22,23] using MDS to approximate hospice eligibility criteria, thus implying limited life expectancy. Advanced dementia criteria included the following: diagnosis of Alzheimer disease or other dementia, advanced cognitive impairment as defined by a score of 3 (moderate impairment) or 4 (severe impairment) on the Cognitive Function Scale,[24] and extensive or total assistance needed for eating and transferring. Advanced CHF was defined as follows: CHF diagnosis, shortness of breath while sitting or supine, and extensive or total assistance needed for transferring. Advanced COPD was

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defined as follows: diagnosis of COPD (including emphysema and asthma), shortness of breath while sitting or supine, and extensive or total assistance needed for transferring.

Covariates

Age, sex, nonwhite race, dual-eligible status indicating beneficiaries qualifying for both Medicare and Medicaid, MDS 3.0 mortality risk score (MRS3),[25] and cohort year were ascertained from the baseline MDS assessment. The MRS3 (0-39) is a validated risk score based on demographic, clinical, and functional characteristics, with higher values indicating greater 30- and 60-day mortality risk. An MRS3 score of 8 or higher is associated with a 5.4 times increased odds of 30-day mortality compared with scores lower than 8.[25]

Outcomes

Residents were followed for up to 12 months from their baseline MDS assessment using Medicare claims from January 1, 2011, to December 31, 2017, to ascertain the occurrence of hospital transfers for all causes, potentially avoidable conditions, and serious bone fractures. Thus, person-time and outcomes spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017). Hospital transfers included acute hospitalizations, observation stays, and emergency department (ED) visits. Hospitalizations were identified from the Medicare Provider Analysis and Review file.[26] Observation stays were defined as any outpatient facility claim for observation services using Healthcare Common Procedure Codes G0378-G0379,[27] *Current Procedural Terminology* codes 99217-99220,[28] or hospital outpatient revenue center code 0762. Emergency department visits were ascertained using outpatient facility claims with revenue center codes 0450-0459 or 0981, Healthcare Common Procedure Codes G0380-G0385, or carrier claims for ED services using *Current Procedural Terminology* codes 99281-99285. Observation stays that became admissions were considered to be hospitalizations. Emergency department visits that became hospitalizations or observation stays were classified accordingly.

Potentially avoidable transfers were identified using ambulatory care-sensitive conditions,[7-11] including sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD (including emphysema and asthma) (eTable 1 in the Supplement). These conditions account for 78% of the potentially avoidable hospitalizations among nursing home residents.[9] Serious bone fractures were examined as counterfactual conditions that usually result in hospital transfers regardless of existing policies and included fractures of the pelvis, hip, long bones of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula), wrists, and ankles (eTable 1 in the Supplement). We classified hospital transfers for these conditions using the claim's principal diagnosis. Mortality and hospice enrollment within 12 months after the baseline assessment were identified from the Medicare Master Beneficiary Summary File[29] and the 2011 to 2017 hospice claims, respectively.

Statistical Analysis

The data were analyzed from October 24, 2018, to October 3, 2019. Descriptive analyses were performed for resident characteristics and outcomes using means with SDs for continuous variables and proportions for categorical variables. Descriptive results were generated for each advanced illness group stratified by cohort year. Hospital transfers were further described by type (hospitalizations, observation stays, and ED visits) and by condition (all causes, potentially avoidable, and serious bone fractures). The proportion of potentially avoidable transfers attributable to specific diagnoses (eg, sepsis, pneumonia) were also calculated and presented graphically. Outliers defined as residents with all-cause hospital transfer rates exceeding 365 transfers per person-year alive across 12 months were removed (<1% of residents across all cohorts combined). Hospital transfer outcomes across 12 months were measured as the proportion of residents who experienced at least 1 transfer and the number of transfers per person-year alive. Mortality and hospice enrollment outcomes across 12 months were measured as the proportion of residents who experienced the event and the time to event. For all models, the main independent variable was the cohort year, with 2011 as the referent category. All models were adjusted for age, sex, nonwhite race, and MRS3 score. All models were fitted using generalized estimating equations to account for clustering within nursing homes and included an offset for log-transformed person-time.

Binary outcomes (any hospital transfers, hospice enrollment, and mortality) were analyzed using log-linked binomial models to estimate relative risk with cohort year. Zero-inflated Poisson regression models were used to analyze outcomes measured as number of transfers per person-year alive to allow for overdispersion owing to the high proportion of residents without a hospital transfer.[30] Adjusted risk ratios (aRRs) and 95% CIs were generated for these analyses. Finally, Cox proportional hazards regression models were used to analyze time-to-event outcomes (hospice enrollment, mortality) across 12 months of follow-up. In the hospice model, death without hospice was considered to be a competing risk. Adjusted hazard ratios and 95% CIs were estimated from these analyses. Analyses were performed using SAS, version 9.4 (SAS Institute Inc).

Results

Table 1 gives the characteristics of the nursing home residents by cohort year and advanced illness group. The 2011 cohort sizes were smaller for all illness groups compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used. Nonetheless, the overall distributions of age and sex were similar across cohort years within illness groups. Residents with advanced CHF (10.1-10.9) and COPD (9.0-9.6) generally had higher MRS3 scores (higher mortality risk) compared with residents with advanced dementia (7.5-8.4). All cohorts were predominately female, white, and dually eligible for Medicare and Medicaid.

Table 2 provides hospital transfer outcomes. All-cause hospital transfers were common in all illness groups across all years and were consistently lower for residents with advanced dementia compared with other groups. The most pronounced reduction in transfers occurred from the 2011 to 2012 cohort and

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Table 1. Characteristics of Nursing Home Residents With Advanced Illness by Cohort Year[a]

Characteristic	Cohort Year[a] 2011[b]	2012	2013	2014	2015	2016
Advanced Dementia						
Residents, No.	18 178[b]	44 385	50 725	53 078	53 418	52 221
Follow-up, mean (SD), d	232.5 (146.0)	238.2 (143.6)	242.8 (143.0)	241.8 (142.4)	243.6 (142.7)	238.7 (143.5)
Age, mean (SD), y	85.0 (7.6)	85.4 (7.6)	85.6 (7.8)	85.8 (7.8)	85.9 (7.9)	85.8 (8.0)
Female, No. (%)	12 400 (68.2)	30 760 (69.3)	35 630 (70.2)	37 303 (70.3)	37 906 (71.0)	36 572 (70.0)
Nonwhite race, No. (%)	3196 (17.6)	7312 (16.5)	8140 (16.0)	8508 (16.0)	8467 (15.9)	8464 (16.2)
Dual eligible, No. (%)[c]	12 654 (69.6)	32 238 (72.6)	37 522 (74.0)	39 462 (74.3)	39 558 (74.1)	39 280 (75.2)
MRS3, mean (SD)[d]	8.4 (3.6)	8.1 (3.6)	7.9 (3.5)	7.7 (3.4)	7.6 (3.4)	7.5 (3.3)
Advanced Congestive Heart Failure						
Residents, No.	8866[b]	16 667	17 782	17 392	17 562	18 931
Follow-up, mean (SD), d alive	207.8 (149.3)	217.8 (148.1)	228.5 (146.7)	226.1 (146.1)	223.9 (148.0)	218.9 (149.5)
Age, mean (SD), y	84.2 (8.1)	84.5 (8.2)	84.5 (8.3)	84.5 (8.5)	84.5 (8.6)	84.3 (8.6)
Female, No. (%)	5994 (67.6)	11 484 (68.9)	12 247 (68.9)	11 999 (69.0)	12 183 (69.4)	12 865 (68.0)
Nonwhite race, No. (%)	1417 (16.0)	2429 (14.6)	2544 (14.3)	2454 (14.1)	2338 (13.3)	2812 (14.9)
Dual eligible, No. (%)[c]	6447 (73.1)	12 665 (76.0)	13 437 (75.6)	13 216 (76.0)	13 097 (74.6)	14 224 (75.1)
MRS3, mean (SD)[d]	10.7 (3.3)	10.9 (3.1)	10.8 (3.0)	10.5 (3.0)	10.7 (3.0)	10.1 (2.9)
Advanced Chronic Obstructive Pulmonary Disease						
Residents, No.	8467[b]	16 597	17 806	17 166	17 409	19 154
Follow-up, mean (SD), d alive	220.5 (148.3)	233.8 (144.8)	243.7 (143.3)	241.9 (142.7)	242.1 (143.9)	239.5 (144.8)
Age, mean (SD), y	82.8 (8.2)	83.1 (8.2)	83.1 (8.4)	83.2 (8.6)	83.1 (8.5)	83.1 (8.6)
Female, No. (%)	5584 (64.6)	10 818 (65.2)	11 788 (66.2)	11 303 (65.8)	11 573 (66.5)	12 668 (66.1)
Nonwhite race, No. (%)	1386 (16.0)	2422 (14.6)	2523 (14.2)	2441 (14.2)	2310 (13.3)	2775 (14.5)
Dual eligible, No. (%)[c]	6566 (75.9)	12 933 (77.9)	14 019 (78.7)	13 499 (78.6)	13 414 (77.1)	15 121 (78.9)
MRS3, mean (SD)[d]	9.6 (3.3)	9.6 (3.2)	9.6 (3.0)	9.4 (3.0)	9.3 (2.9)	9.0 (3.0)

Abbreviations: MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS 3.0 assessments from 2011 to 2016.

[b] Cohort sizes from 2011 were smaller compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used.

[c] Beneficiaries who qualify for both Medicare and Medicaid benefits.

[d] MDS 3.0 mortality risk score, range 0-39; higher scores indicate higher risk of mortality.

then from the 2012 to 2013 cohort. Data showed no further reduction after 2013 and higher rates in 2016 than in 2015, particularly in the CHF and COPD cohorts. The adjusted proportions of residents who had at least 1 hospital transfer for any cause in the 2011 and 2016 cohorts were 56.1% and 45.4% for those with advanced dementia, 77.6% and 69.5% for those with CHF, and 76.2% and 67.2% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for any cause was higher in the 2011 vs 2016 cohorts for nursing home residents with advanced dementia, 5.8 (22.7) vs 3.9 (17.9); CHF, 16.8 (43.9) vs 13.5 (38.9); and COPD, 15.6 (42.4) vs 11.2 (35.8). For each illness, the decrease in transfer rates between the 2011 and 2016 cohorts remained significant (advanced dementia [aRR, 0.72; 95% CI, 0.67-0.78]; CHF [aRR, 0.74; 95% CI, 0.68-0.80]; and COPD [aRR, 0.66; 95% CI, 0.61-0.72]) after adjustment for baseline characteristics. As demonstrated in **Figure 1**, reductions in hospital transfer rates over time were almost entirely attributable to declines in acute hospitalizations in each illness group.

Transfers for potentially avoidable conditions were common and decreased over time in each illness group in patterns similar to those of transfers for all causes (Table 2). The adjusted proportions of residents having at least 1 hospital transfer for a potentially avoidable condition in the 2011 and 2016 cohorts, respectively, were 26.5% and 20.4% for those with advanced dementia; 50.0% and 42.9% for those with CHF; and 49.2% and 40.7% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for potentially avoidable conditions for the 2011 vs 2016 cohorts were 2.4 (14.0) vs 1.6 (11.2) (aRR, 0.73; 95% CI, 0.65-0.81) for those with advanced dementia; 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81) for those with CHF; and 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72) for those with COPD. Sepsis was the most frequent condition attributed to potentially avoidable transfers in all cohort years for all groups (**Figure 2**). The next most frequent conditions documented for potentially avoidable transfers were pneumonia and urinary tract infections for advanced dementia and CHF and pneumonia for both advanced CHF and COPD.

Hospital transfers for a primary diagnosis of serious bone fractures were relatively uncommon and, as hypothesized, remained unchanged for all advanced illness groups across all years (Table 2). **Table 3** gives the mortality and hospice enrollment outcomes. Hospice enrollment was low across all illness groups and years (range, 23%-30%). Mortality within 1 year exceeded 50% for all advanced illness groups across all years but did not increase over time in any illness group. Hospice use

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Table 2. Hospital Transfer Outcomes Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
Any transfer, adjusted % (95% CI)[b]						
All causes	56.1 (55.4-56.9)	51.1 (50.5-51.4)	45.9 (45.6-46.4)	45.1 (44.7-45.5)	44.5 (44.1-44.9)	45.4 (44.9-45.8)
Potentially avoidable[c]	26.5 (25.9-27.2)	23.2 (22.8-23.6)	20.0 (19.6-20.3)	19.7 (19.4-20.1)	19.5 (19.2-19.8)	20.4 (20.1-20.7)
Fractures[d]	2.4 (2.2-2.6)	2.3 (2.2-2.5)	2.3 (2.1-2.4)	2.3 (2.2-2.5)	2.4 (2.2-2.5)	2.4 (2.3-2.6)
Hospital transfers per person-year alive						
All causes, mean (SD)	5.8 (22.7)	4.1 (16.7)	3.3 (14.4)	3.1 (13.6)	3.2 (14.2)	3.9 (17.9)
Adjusted RR[b]	1 [Reference]	0.71 (0.66-0.77)	0.58 (0.54-0.62)	0.56 (0.52-0.60)	0.57 (0.53-0.62)	0.72 (0.67-0.78)
Potentially avoidable, mean (SD)[c]	2.4 (14.0)	1.6 (10.2)	1.2 (7.8)	1.2 (7.6)	1.2 (8.0)	1.6 (11.2)
Adjusted RR[b]	1 [Reference]	0.67 (0.60-0.75)	0.52 (0.47-0.58)	0.51 (0.46-0.57)	0.53 (0.48-0.59)	0.73 (0.65-0.81)
Fractures, mean (SD)[d]	0.06 (0.78)	0.06 (0.87)	0.05 (0.82)	0.06 (0.72)	0.07 (1.08)	0.08 (1.24)
Adjusted RR	1 [Reference]	0.98 (0.77-1.24)	0.85 (0.67-1.07)	0.93 (0.75-1.16)	1.03 (0.81-1.30)	1.28 (1.00-1.61)
Advanced Congestive Heart Failure						
Any transfer, adjusted % (95% CI)[b]						
All causes	77.6 (76.7-78.5)	69.3 (68.6-70.0)	63.6 (62.9-64.3)	63.2 (62.5-63.9)	64.7 (63.9-65.4)	69.5 (68.9-70.2)
Potentially avoidable[c]	50.0 (49.9-51.1)	41.5 (40.7-42.2)	36.4 (35.7-37.1)	36.6 (35.8-37.3)	38.1 (37.3-38.8)	42.9 (42.2-43.6)
Fractures[d]	2.0 (1.8-2.3)	1.9 (1.8-2.2)	2.0 (1.8-2.2)	2.1 (1.9-2.3)	2.0 (1.8-2.2)	2.0 (1.8-2.2)
Hospital transfers per person-year alive						
All causes, mean (SD)	16.8 (43.9)	11.1 (33.6)	8.0 (24.1)	8.0 (24.3)	9.6 (28.3)	13.5 (38.9)
Adjusted RR[b]	1 [Reference]	0.69 (0.64-0.75)	0.49 (0.45-0.53)	0.49 (0.45-0.53)	0.57 (0.53-0.62)	0.74 (0.68-0.80)
Potentially avoidable, mean (SD)[c]	8.5 (32.0)	5.2 (23.5)	3.5 (15.8)	3.4 (15.1)	4.5 (19.6)	6.7 (26.8)
Adjusted RR[b]	1 [Reference]	0.64 (0.58-0.72)	0.42 (0.38-0.47)	0.42 (0.38-0.47)	0.53 (0.48-0.59)	0.72 (0.65-0.81)
Fractures, mean (SD)[d]	0.08 (1.20)	0.08 (1.59)	0.08 (1.01)	0.07 (1.01)	0.07 (1.21)	0.90 (2.37)
Adjusted RR	1 [Reference]	0.99 (0.65-1.51)	0.86 (0.60-1.24)	0.84 (0.58-1.21)	0.82 (0.55-1.21)	1.02 (0.63-1.63)
Advanced Chronic Obstructive Pulmonary Disease						
Any transfer, adjusted % (95% CI)[b]						
All causes	76.2 (75.3-77.1)	69.1 (68.4-69.9)	63.3 (62.6-64.0)	63.1 (62.3-63.8)	63.9 (63.2-64.7)	67.2 (66.6-67.9)
Potentially avoidable[c]	49.2 (48.2-50.2)	41.2 (40.4-41.9)	35.9 (35.2-36.6)	36.0 (35.3-36.7)	37.2 (36.4-37.9)	40.7 (40.0-41.4)
Fractures[d]	2.3 (2.0-2.6)	2.2 (2.0-2.5)	2.3 (2.1-2.6)	2.4 (2.2-2.6)	2.2 (2.0-2.5)	2.2 (2.0-2.5)
Hospital transfers per person-year alive						
All causes, mean (SD)	15.6 (42.4)	9.9 (30.2)	7.3 (22.1)	7.7 (24.8)	8.6 (27.4)	11.2 (35.8)
Adjusted RR[b]	1 [Reference]	0.60 (0.55-0.65)	0.43 (0.39-0.46)	0.46 (0.41-0.49)	0.50 (0.46-0.55)	0.66 (0.61-0.72)
Potentially avoidable, mean (SD)[c]	7.8 (30.9)	4.6 (21.1)	3.1 (14.3)	3.2 (15.5)	3.8 (17.5)	5.5 (24.8)
Adjusted RR[b]	1 [Reference]	0.55 (0.49-0.62)	0.36 (0.32-0.41)	0.37 (0.33-0.42)	0.44 (0.39-0.49)	0.64 (0.57-0.72)
Fractures, mean (SD)[d]	0.09 (1.19)	0.07 (0.98)	0.08 (0.98)	0.09 (1.08)	0.07 (0.74)	0.95 (2.16)
Adjusted RR	1 [Reference]	0.79 (0.55-1.11)	0.82 (0.58-1.14)	0.88 (0.63-1.23)	0.69 (0.50-0.96)	.095 (0.63-1.46)

Abbreviations: COPD, chronic obstructive pulmonary disease; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score; RR, relative risk.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

[b] All models were adjusted for age, sex, nonwhite race, and MRS3 and included an offset for log(person-time).

[c] Transfers for primary diagnosis of sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD or asthma.

[d] Fractures of pelvis, hip, wrist, ankle, and long bone fractures of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula).

was low for all illnesses across all years but increased slightly for the 2016 cohort of residents with advanced dementia.

Discussion

We examined changes in national hospital transfer rates among long-stay nursing home residents with advanced dementia, CHF, and COPD from 2011 to 2017, a period during which national initiatives were introduced to reduce hospital transfers across care settings, including the long-term care setting. Transfers for all causes and potentially avoidable conditions declined for each advanced illness group during these years without adversely affecting mortality. This decline was almost entirely attributable to a reduction in hospitalizations rather than in observation stays or ED visits. In contrast, transfer rates for serious bone fractures, which are less likely to be associated with policy changes, remained stable. Sepsis and pneumonia were common reasons for potentially avoidable hospital transfers across all groups. Although the hospital transfer rates for all causes and potentially avoidable conditions declined, they remained common. In the 2016 cohorts, 45% of the residents with advanced

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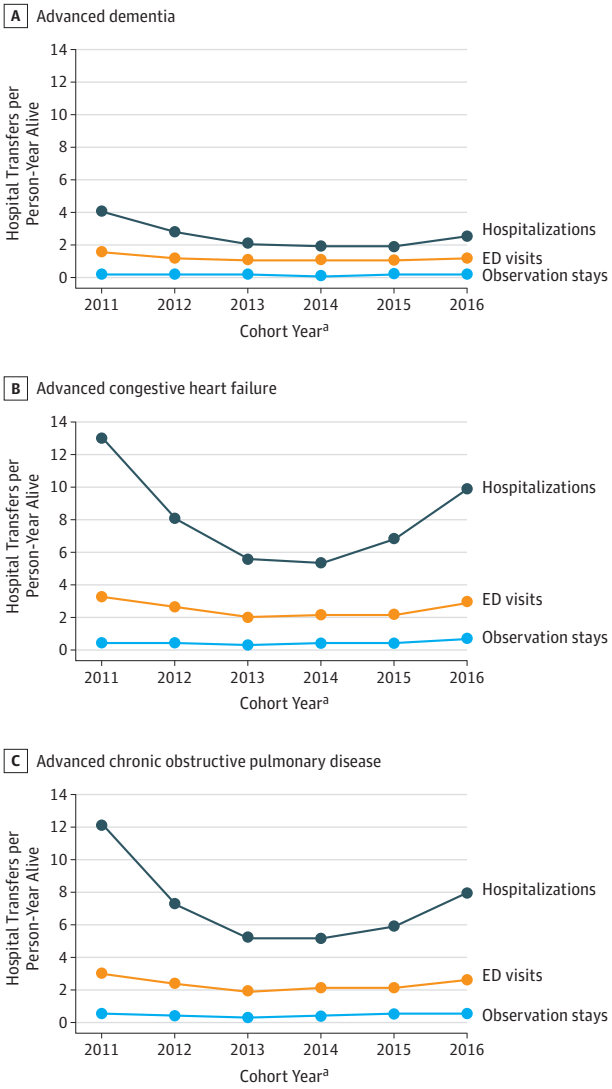
Figure 1. Transfer Rates for Hospitalizations, Emergency Department (ED) Visits, and Observation Stays for Illness Groups by Cohort Year



[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

dementia and roughly two-thirds of those with advanced CHF and COPD experienced at least 1 transfer despite the greater than 50% mortality rate across all groups. These observations, coupled with low hospice enrollment throughout all years, suggest that opportunities remain to further reduce hospital transfers and improve end-of-life care for nursing home residents with advanced illnesses.

Although several studies describe changes in hospitalization rates in the United States in 2014 and 2015,[17,18,31-33] the present study focused on long-term care residents with advanced illness. The issue is particularly pertinent for this population because hospital transfers can be especially burdensome, of little clinical benefit, and distressing for family members.[3-5,34] Treatment decisions should be guided by patient preferences. Thus, if the decline in transfer rates observed in this study reflect, in part, decisions to avoid hospitalizations in favor of comfort-focused care, then such care should be available in the nursing home. High-quality palliative care is currently lacking in many US nursing homes.[35-37] Palliative care and hospice improve the quality of end-of-life care among nursing home residents, including reducing hospitalization rates.[32,36-39] Although we could not ascertain whether residents received palliative care outside the Medicare Hospice Benefit, we observed low rates of hospice enrollment and no concurrent uptake of hospice as hospital transfer rates declined. Given the increased scrutiny and federal audits of nursing homes with long hospice stays, the present study suggests that most residents with advanced dementia, CHF, and COPD are not receiving hospice care near the end of life.

Potentially avoidable hospital transfers among dual-eligible beneficiaries are key quality measures in long-term care and cost Medicare an estimated $2.6 billion annually.[9,40] Infections accounted for most potentially avoidable hospital transfers across advanced illness groups. Among residents with advanced CHF and COPD, exacerbations of these underlying conditions were also common reasons for transfers. Consequently, advance care planning among providers, residents, and family members presents a critical opportunity for informed decision-making about wishes for future hospitalizations in anticipation of expected clinical complications, and online resources are available to help guide these discussions.[41] Proxies of residents with advanced dementia should understand that recurrent infections are a hallmark of the end stage of the disease. Among residents with advanced illness for whom curative care remains aligned with their preferences, infections and cardiopulmonary decompensations can often be managed in the nursing home.[3,42-45] Of note, mortality did not increase across the cohort years in any group despite the decline in hospital transfers.

Programmatic initiatives, such as Interventions to Reduce Acute Care Transfers (INTERACT),[46] have been adopted widely to avoid unnecessary hospitalizations by improving the nursing home's capacity to provide on-site evaluation and management of acute changes through early recognition, monitoring, and staff training. Although a recent cluster randomized clinical trial of INTERACT demonstrated no effect on hospitalizations or ED visits, the trial highlighted the complexities of implementing and sustaining such interventions in nursing homes.[16]

This study's findings are consistent with those of studies documenting prominent declines in hospitalization and readmission rates between 2010 and 2012 after the enactment of the ACA and announcement of the HRRP, a Medicare value-based purchasing program that financially penalizes hospitals with excess readmissions for specific conditions.[17,18,47-49] Health care systems may have made systemic preparations in anticipation of the HRRP penalty phase in October 2012. Our findings also support the possible spillover effect of HRRP onto nonspecific conditions.[17,18,47,48,50] Consistent with other studies, we

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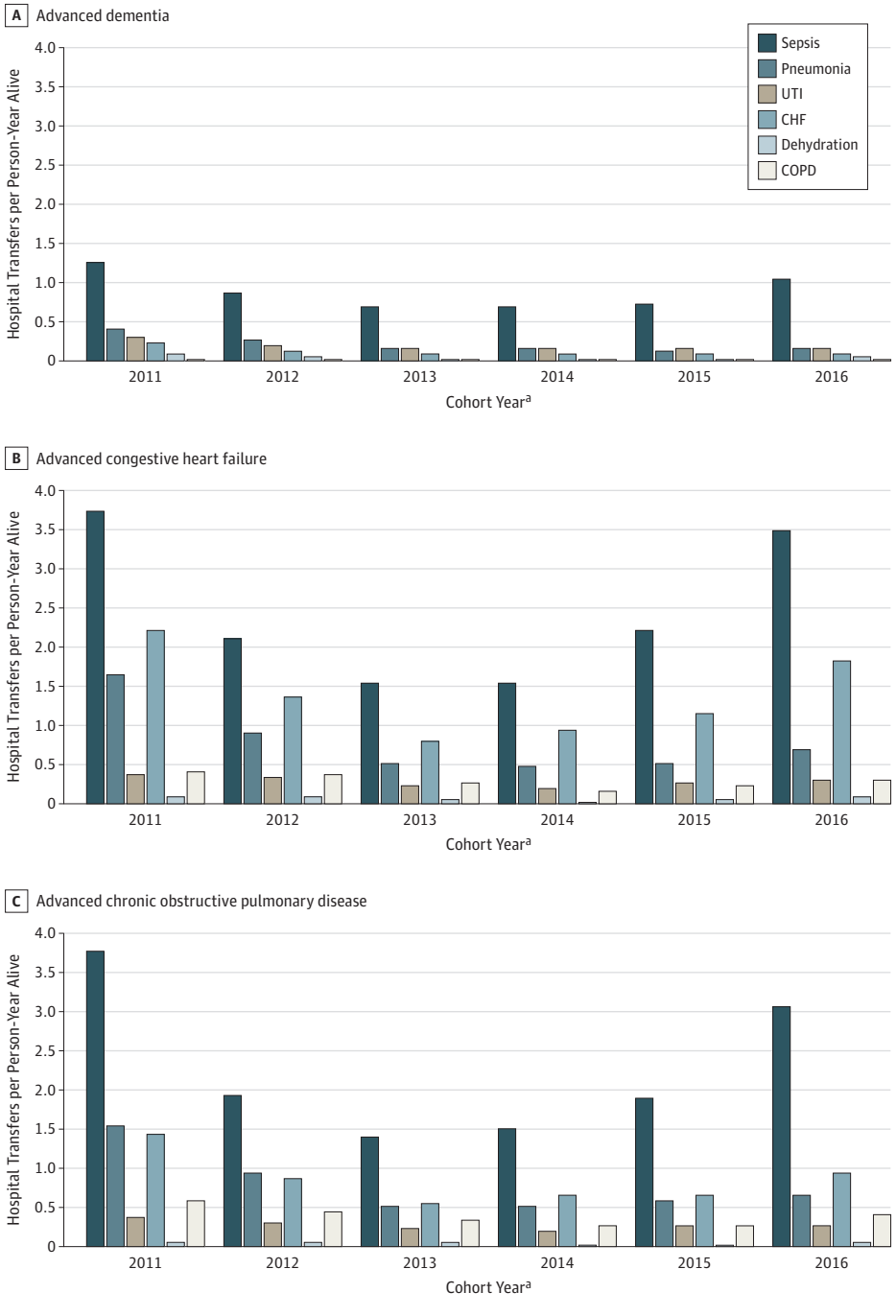
Figure 2. Hospital Transfer Rates for Potentially Avoidable Conditions by Cohort Year



CHF indicates congestive heart failure; COPD, chronic obstructive pulmonary disease; and UTI, urinary tract infection.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

observed a leveling off of hospital transfer rates during 2014 to 2016.[17,18,47,48] Chhabra and colleagues[48] suggest that this pattern may reflect a floor effect—a point at which achieving additional reductions in rates becomes more difficult. Regression to the mean may also partly explain the marked decline observed in transfer rates compared with those in 2011.[33]

Several factors acting in parallel may contribute to the observed declines in potentially avoidable transfers. Increased attention and quality and performance improvement initiatives have targeted unnecessary hospital transfers. Recent studies demonstrate reductions in hospital readmissions for potentially avoidable conditions after implementation of the HRRP.[17,18] Although nursing homes were not subject to financial penalties under HRRP, many nursing homes across the United States adopted quality improvement programs, such as INTERACT, in anticipation of CMS quality assurance and performance improvement regulations.[46] In addition, nursing homes included in accountable care organizations or other preferred referral

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Table 3. Mortality and Hospice Enrollment Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
12-mo Mortality adjusted						
% (95% CI)[b]	52.8 (51.6-53.1)	51.8 (51.3-52.3)	50.5 (50.1-51.0)	52.0 (51.6-52.5)	51.0 (50.5-51.4)	53.3 (52.8-53.7)
HR (95% CI)[c]	1 [Reference]	0.97 (0.95-1.00)	0.94 (0.92-0.96)	0.98 (0.95-1.00)	0.95 (0.93-0.98)	1.02 (0.99-1.04)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.2 (26.5-27.8)	26.9 (26.5-27.4)	27.1 (26.7-27.4)	27.2 (26.9-27.6)	27.9 (27.6-28.3)	30.0 (29.6-30.4)
HR (95% CI)[d]	1 [Reference]	0.97 (0.94-1.01)	0.97 (0.94-1.00)	0.98 (0.95-1.02)	1.01 (0.98-1.04)	1.11 (1.08-1.15)
Advanced CHF						
12-mo Mortality adjusted						
% (95% CI)[b]	61.6 (60.6-62.6)	58.9 (58.1-59.6)	55.4 (54.7-56.2)	56.8 (56.0-57.5)	56.3 (55.5-57.0)	57.3 (56.6-58.0)
HR (95% CI)[c]	1 [Reference]	0.94 (0.90-0.99)	0.87 (0.83-0.91)	0.87 (0.84-0.90)	0.87 (0.84-0.90)	0.89 (0.86-0.92)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.9 (27.0-28.9)	27.1 (26.4-27.8)	25.8 (25.2-26.5)	26.9 (26.2-27.5)	27.4 (26.7-28.0)	29.9 (29.2-30.5)
HR (95% CI)[d]	1 [Reference]	0.94 (0.89-0.99)	0.87 (0.83-0.91)	0.91 (0.87-0.95)	0.93 (0.89-0.98)	1.03 (0.98-1.08)
Advanced COPD						
12-mo Mortality adjusted						
% (95% CI)[b]	57.8 (56.7-58.9)	53.6 (52.8-54.3)	49.9 (49.0-50.5)	51.3 (50.6-52.1)	50.7 (50.0-51.5)	52.2 (51.4-52.9)
HR (95% CI)[c]	1 [Reference]	0.88 (0.85-0.91)	0.80 (0.77-0.82)	0.82 (0.79-0.85)	0.82 (0.79-0.85)	0.85 (0.82-0.88)
Hospice in 12 mo adjusted						
% (95% CI)[b]	24.7 (23.8-25.6)	23.9 (23.2-24.6)	23.1 (22.5-24.0)	23.3 (22.7-24.0)	24.1 (23.4-24.7)	26.2 (25.6-26.9)
HR (95% CI)[d]	1 [Reference]	0.92 (0.87-0.97)	0.87 (0.82-0.91)	0.87 (0.83-0.92)	0.91 (0.86-0.95)	1.00 (0.95-1.05)

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify outcomes occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and outcomes were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017).

[b] Adjusted for age, sex, nonwhite race, and MRS3 and offset for person-time.

[c] Adjusted for age, sex, nonwhite race, and MRS3. Mortality: HR <1.00 indicates lower rate of death relative to rate in 2011.

[d] Adjusted for age, sex, nonwhite race, and MRS3. Death was considered a competing risk. Hospice: HR <1.00 indicates lower rate of hospice enrollment relative to rate in 2011.

networks were further incentivized to reduce hospitalizations to remain in network.[16] The CMS is conducting demonstration projects to examine payment models that include value-based purchasing incentives as part of the initiative to reduce avoidable hospitalizations among nursing home residents.[10] The Skilled Nursing Facility (SNF) value-based purchasing program took effect in October 2018 to extend penalties for excess readmissions to SNFs; preliminary data suggest that 73% of SNFs face financial penalties after failing to achieve benchmarks.[51]

Previous research in long-term care settings has focused almost exclusively on potentially avoidable hospitalizations. The present study extends prior work to include all potentially avoidable hospital transfers, including ED visits and observation stays. We found that declines in all-cause hospital transfer rates were almost exclusively associated with reductions in acute hospitalizations, and the rates of observation stays remained low between 2011 and 2017. Thus, concerns that hospitals may shift admissions to observation stay status to avoid HRRP penalties[18] appear to be unfounded in this population. In addition, rates of decline were similar for all-cause and potentially avoidable transfers, suggesting that broader efforts are being made to reduce hospital transfers or that there is a spillover effect from the focus on potentially avoidable conditions. Although we observed reductions in potentially avoidable hospital transfers, several thousand nursing home residents with advanced illness continue to be transferred to hospitals near the end of life. We estimated 708 096 transfers for all-cause transfers across the 3 advanced illness cohorts from 2011 to 2017, of which 259 339 (36.8%) were potentially avoidable. Moreover, despite the initial reduction in potentially avoidable transfers from 39.1% in 2011 to 35.1% in 2013, the rate appears to have rebounded to 37.7% by 2016 (eTable 2 and eFigure in the Supplement).

Limitations

This study has limitations. The application of claims-based measures of potentially avoidable conditions to nursing home populations remains controversial because they do not capture the complex health status of frail, older nursing home residents with multimorbid conditions or the specific challenges of managing acute illnesses in this population and setting.[7,45] Moreover, insurance claims and MDS 3.0

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assessments do not fully capture the circumstances leading to decisions for hospital transfer, including advance directives. Important drivers of decisions to transfer are associated with decisional processes and organizational factors, including communication, family preferences, and nursing home resources.[52-56] Furthermore, the principal diagnoses listed on hospital claims are assigned at discharge as the diagnosis that was chiefly responsible for the admission, whereas the diagnosis assigned to an ED visit or observation stay is based on more limited information.[57] However, we focused on long-term care residents with advanced illness for whom care decisions should align with values and goals of care and for whom the harms associated with hospital transfers usually outweigh possible benefits.[3-5]

Conclusions

Hospital transfer rates for all causes and for potentially avoidable causes declined in 2017 compared with 2011 for long-stay nursing home residents with advanced dementia, CHF, or COPD, with no increase in mortality. Reductions in potentially avoidable transfers are encouraging, yet many residents still experienced multiple transfers for infections and CHF or COPD exacerbations. These findings indicate important opportunities to improve care of nursing home residents with advanced illness through improvements in advance care planning, acute care management, and the delivery of high-quality palliative care.

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Letters

RESEARCH LETTER

Temporal Trends in the Numbers of Skilled Nursing Facility Specialists From 2007 Through 2014

Residents of nursing homes (NHs) comprise a medically complex and vulnerable population with many persons experiencing multiple comorbid conditions, frailty, and advanced dementia. Health care professionals such as physicians, nurse practitioners (NPs), and physician assistants (PAs) play an important role in managing their care. An Office of Inspector General Report[1] noted that specialization of health care professionals in NH care could potentially improve care through increased presence of health care professionals in NHs, enhanced knowledge in the care of patients with medically complex conditions, and better understanding of the regulatory environment. On the contrary, specialization in 1 setting of care could result in increased fragmentation of care, giving rise to concerns about medical errors and lack of care coordination. Little empirical research is available about the number of clinicians who primarily practice in NHs or the proportion of NH care delivered by these clinicians.[2] Using national Medicare Part B claims from 2007, 2010, and 2014, we characterized temporal trends in the number of physicians, NPs, and PAs concentrating their practice in the NH or skilled nursing facility (SNF) setting (ie, SNFists), the fraction of all NH and SNF claims generated by SNFists, and state variation in this phenomenon in 2014.

Editor's Note

Methods | The Medicare Part B Carrier File includes Evaluation and Management codes based on common sites of service: the nursing home, outpatient office, hospital, emergency department, a patient's home, and assisted living, custodial care facilities. Using Evaluation and Management codes from 20% of all Medicare Part B Carrier file claims from 2007, 2010, and 2014, we identified all physicians, NPs, and PAs who billed more than 90% of all their visits in the NH setting. The 90% threshold is consistent with a prior study of hospitalist care in the United States[3]; in a sensitivity analysis, we relaxed this threshold to 50%. Temporal trend comparisons for 2007, 2010, and 2014 were performed using variance-weighted least squares. We further characterized, in each state, the fraction of all outpatient visits in NHs that were accounted for by SNFists. An institutional review board waiver was obtained from Brown University.

Results | Between 2007 and 2014, the proportion of physicians ever billing in an NH decreased from 13.7% to 9.8% (test of trend, $P < .001$) while the number of physicians classified as SNFists increased by 48.2% (1496 vs 2225), increasing from 0.34% to 0.49% of all physicians (**Table**). The number of NPs or PAs classified as SNFists nearly doubled (1678 vs 3074). The proportion of NPs and PAs classified as SNFists remained stable because of increasing numbers of these clinicians. The proportion of all Evaluation and Management bills for care in an NH or SNF submitted by clinicians classified as SNFists increased from 11.6% to 14.3% among physicians (test of trend, $P < .001$) and from 10.4% to 17.2% among NPs and PAs (test of trend, $P < .001$). Between 2007 and 2014, the proportion of total SNF billing accounted for by SNFist clinicians increased from 22.0% to 31.5% (test of trend, $P < .001$). The SNFists' proportion of total NH billing varied by state, amounting to nearly 50% in Delaware, Hawaii, Tennessee, Connecticut, and Massachusetts. In a sensitivity analysis using a threshold of more than 50% of visits in the SNF, the number of physician SNFists increased from 2551 to 3529 and the number of NP or PA SNFists increased from 3267 to 5477.

Table. Physician, Nurse Practitioner, and Physician Assistant Billing in 2007, 2010, and 2014

Billing Category	2007	2010	2014
Physicians, No.	435 943	419 299	459 895
Ever billing in an SNF,[a] No. (%)	59 724 (13.7)	50 814 (12.1)	45 070 (9.8)
Billing ≥90% in an SNF,[a] No. (%)	1496 (0.34)	1697 (0.40)	2225 (0.49)
Nurse practitioners or physician assistants, No.	64 393	80 029	131 986
Ever billing in an SNF,[b] No. (%)	7528 (11.7)	8309 (10.4)	12 470 (9.5)
Billing ≥90% in an SNF,[b] No. (%)	1678 (2.6)	2031 (2.5)	3074 (2.3)
Evaluation and management code bills at SNF, No.	4 731 367	4 538 967	5 205 865
By physician billing ≥90% in an SNF,[c] No. (%)	550 425 (11.6)	584 952 (12.9)	747 106 (14.3)
By nurse practitioner or physician assistant billing ≥90% in an SNF,[c] No. (%)	49 145 (10.4)	581 235 (12.8)	895 830 (17.2)

Abbreviation: SNF, skilled nursing facility.

[a] For the physicians ever billing in an SNF or physicians billing 90% or more in an SNF, the denominator is physicians billing Medicare in that year.

[b] For nurse practitioner or physician assistant billing, the denominator is nurse practitioners or physician assistants billing Medicare in that year.

[c] The denominator for physicians, nurse practitioners, and physician assistants billing at 90% or more is the number of evaluation and management codes billed in a nursing home or SNF in the year 2007, 2010, or 2014.

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Discussion | The care of frail and medically complex NH residents is increasingly performed by NPs and PAs who focus nearly exclusively in this site of care. In some states, SNFists accounted for nearly half of the total billing in the NH setting of care. Future research is needed to understand how this specialization of care affects not only care delivery but the overall experience of frail, elderly patients.

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Critical revision of the manuscript for important intellectual content: Teno, Gozalo, Trivedi, Mitchell, Mor.
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Letters

RESEARCH LETTER

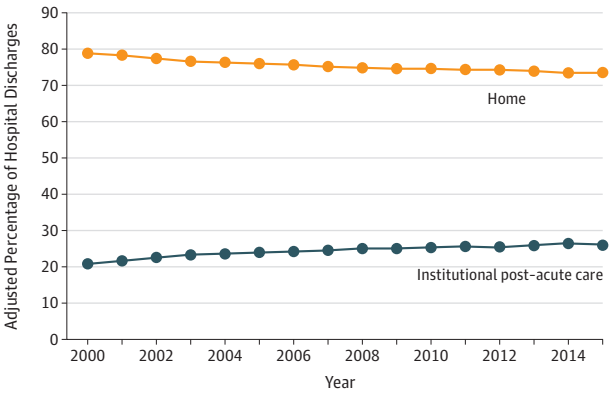
Trends in Post-Acute Care Use Among Medicare Beneficiaries: 2000 to 2015

Since Medicare's adoption of the inpatient prospective payment system in 1983, hospitals have sought ways to reduce costs, resulting in a decrease in hospital length of stay and an increase in the use of institutional post-acute care,[1] making it a major Medicare expenditure.[2] Since the Affordable Care Act passed in 2010, Medicare has implemented payment reforms designed to make hospitals and clinicians accountable for the cost and quality of care delivered. Examples include the Hospital Readmissions Reduction Program (implemented in 2012), accountable care organizations (2012), and bundled payments (2013). How these payment reforms affect the use of post-acute care is unknown.[3] The expense of post-acute care may diminish its use under cost-containment incentives.[4] Alternatively, pressure to reduce costs by reducing unnecessary readmissions may encourage its use. Our objective was to document recent trends in use of institutional post-acute care (including the 2 most common sites: skilled nursing facilities [SNFs] and inpatient rehabilitation facilities [IRFs]) and, simultaneously, hospital and post-acute care length of stay.

Methods | We used the 100% MedPAR file[5] to identify Medicare beneficiaries discharged alive from an acute care hospital between January 2000 and December 2015 (n = 199 069 327), excluding discharges younger than 65 years or discharged to hospice (n = 39 036 324 or 19.6%), enrolled in Medicare Advantage (n = 20 250 852 or 10.2%), or discharged to institutional settings other than SNF or IRF (eg, psychiatric hospital; n = 1 808 518 or 0.9%). We identified each discharge's first post-hospitalization destination (home vs institutional post-acute care) and the number of days in the hospital and post-acute care. We used multivariable regression to predict risk-adjusted annual outcomes adjusted for age, sex, race, and 31 Elixhauser comorbidities. We tested for the statistical significance of differences over time using *t* tests (2-tailed with an α of .05). All analyses were performed using Stata (StataCorp), version 15. This study was approved by the institutional review board of the University of Pennsylvania with a waiver of informed consent.

Results | Among 137 973 633 hospital discharges, 20.3% were discharged to SNFs and 3.7% were discharged to IRFs. The adjusted percentage of hospital discharges to post-acute care increased from 21.0% in 2000 to 26.3% in 2015 (increase of 5.36 percentage points [95% CI, 5.32 to 5.40]; *P* <.001), whereas the adjusted percentage of discharges home decreased from 79.0% in 2000 to 73.6% in 2015 (decrease of 5.36 percentage points [95% CI ,−5.40 to −5.32]; *P* <.001) (**Figure 1**).

Figure 1. Proportion of Medicare Beneficiaries Discharged to Institutional Post-Acute Care vs Discharged Home



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

Among patients discharged to post-acute care, hospital length of stay decreased from 9.0 days in 2000 to 7.3 days in 2015 (decrease of 1.70 days [95% CI, −1.71 to −1.69]; *P* <.001) (**Figure 2**). Among patients discharged home, hospital stays decreased from 5.7 days in 2000 to 4.8 days in 2015 (decrease of −0.91 days [95% CI, −0.92 to −0.91]; *P* <.001). At the same time, length of stay in post-acute care increased from 21.7 days in 2000 to 25.7 days in 2014 (increase of 3.98 days [95% CI, 3.93 to 4.02]; *P* < .001) and then decreased to 25.1 days in 2015 (decrease of 0.54 days [95% CI, 0.50 to 0.59]; *P* < .001).

Discussion | The use of institutional post-acute care increased between 2000 and 2015 and was accompanied by increasing length of post-acute care stays through 2014. These trends did not appear to change when payment reform was implemented under the Affordable Care Act. SNFs (which accounted for 85% of institutional post-acute care) are paid per diem and thus may have strong incentives to maintain longer lengths of stay. This study was limited by the exclusion of Medicare Advantage enrollees. If policy incentives are to effectively reduce SNF length of stay, they might need to align SNF payment with the goal of reducing SNF use.

It is uncertain whether the use of post-acute care benefits patients. Despite its proliferation, there is little evidence that post-acute care improves key patient outcomes—preventing rehospitalizations or improving functional recovery. Further investigating how post-acute care affects patient outcomes is essential.

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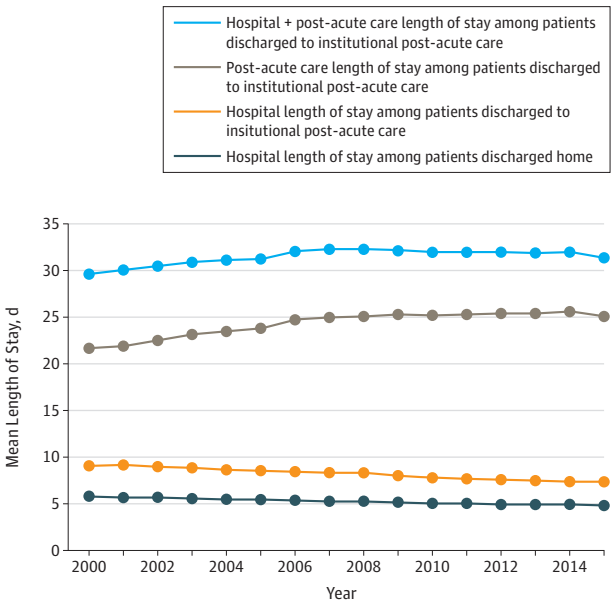
Figure 2. Mean Length of Stay in the Hospital, in Post–Acute Care, and in the Combination of Hospital Plus Post–Acute Care



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

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Author Contributions: Dr Werner had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Both authors.
Acquisition, analysis, or interpretation of data: Werner.
Drafting of the manuscript: Werner.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Both authors.
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COMMENT & RESPONSE

Diagnosis and Treatment of Hidradenitis Suppurativa

To the Editor Drs Saunte and Jemec performed an illustrative review focused on the advances in diagnosis and treatment of hidradenitis suppurativa (HS).[1] However, the advances in imaging of the disease were not discussed.

For example, regarding the pathogenesis, ultrasound studies have allowed visualization of the hidden connections between the tunnels or fistulous tracts and fluid collections and the dilated and ruptured base of the hair follicles, which were illustrated in Figure 3 in the article.[1-3] Regarding the staging of hidradenitis, ultrasonography has also demonstrated that clinical evaluation and commonly used clinical scoring systems can miscategorize as healthy skin corporal segments with fluid collections or fistulous tracts underneath.[3] The latter findings on imaging can be critical because, as pointed out by the authors, the choice of therapy is guided by disease severity. Currently, color Doppler ultrasound can support the detection of key subclinical lesions, the staging of the disease, and the assessment of activity and has been added to the clinical evaluation of hidradenitis in many centers around the world.[3,4] Moreover, ultrasound is also being used in ongoing trials.

In patients with indications for local or systemic treatments, imaging can be a noninvasive tool for monitoring the response. In patients with a surgical indication, an image-guided mapping of the extent of the abnormalities can be performed. Ultrasound has the ability to detect, categorize, and measure the lesions in all the corporal regions affected by hidradenitis.[3] This imaging information may allow better selection of the type of medical treatment or the location and extent of the surgical incision.[3]

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported receiving personal fees from Abbvie, Novartis, Janssen-Cilag, and Springer.

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CLINICAL INVESTIGATION

Successful Discharge to Community Gap of FFS Medicare Beneficiaries With and Without ADRD Narrowed

Barbara H. Bardenheier, PhD,†‡ Momotazur Rahman, PhD,*‡ Cyrus Kosar, MS,*‡ Rachel M. Werner, MD, PhD,§¶ and Vincent Mor, PhD*‡*

BACKGROUND/OBJECTIVES: We sought to compare the post-acute and long-term care experience of Medicare beneficiaries with and without Alzheimer Disease and Related Dementias (ADRD), and whether differences changed from January 1, 2007 to September 30, 2015.

DESIGN: Retrospective cross-sectional trend study using Medicare claims linked to the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set.

SETTING: CMS-certified skilled nursing facilities (skilled nursing facility (SNF), n = 17,043).

PARTICIPANTS: Fee-for-service Medicare beneficiaries aged ≥66 years (n = 6,614,939) discharged from a hospital to a SNF who had not lived in a nursing home during the year before hospitalization.

MEASUREMENTS: ADRD was defined by the Chronic Condition Data Warehouse. Outcome measures included: (1) successful discharge defined as being in SNF less than 90 days, then discharged back to the community, alive without subsequent inpatient health care for 30 continuous days; (2) became long-stay resident in SNF; (3) death in SNF within 90 days; (4) hospital readmission within 30 days of entering SNF; and (5) transferred to another nursing home within 30 days of entering SNF.

RESULTS: Successful discharge of beneficiaries with ADRD increased from 43.4% in 2007 to 53.9% in 2015 (average annual percent change (AAPC) = 2.1 (95% CI = 2.0–2.2)); those without ADRD also increased (from 59.1% to 63.6%, AAPC = 0.9 (95% CI = 0.7–1.1)) but not as fast as those with ADRD ($P < .01$). The proportion of all beneficiaries who became long-stay or were readmitted to the hospital decreased ($P < .05$). The proportion with ADRD who became long-stay was nearly three times higher than those without throughout the study (15.0% vs 5.5% in 2007; 11.3% vs 4.3% in 2015).

CONCLUSION: Though disparity in ADRD in becoming long-stay residents remains, the increase in successful discharges among those with ADRD also stresses the increasing importance of community as a care setting for adults with ADRD. **J Am Geriatr Soc 00:1-7, 2020.**

Keywords: ADRD; successful discharge; disparity

INTRODUCTION

Between 2010 and 2016 20.3% of Medicare beneficiaries received post-acute care (PAC) services in a skilled nursing facility (SNF) after being discharged from the hospital.[1] The improving Medicare Post-Acute-Care Transformation Act of 2014 mandated addition of a national quality measure for successful community discharge from PAC services. Although the goal of PAC rehabilitation is to maximize independence and facilitate a safe community transition, some SNF patients may be awaiting family arrangements to provide care at home or for selection of a long-term nursing facility. Some may need to stabilize and to get their numerous medical conditions to a manageable care plan. But generally, returning to and remaining in the community after an illness, injury, or surgery reflects the quality of PAC[2] (https://impactcollaboratory.org/). Although some studies have assessed inpatient rehabilitation facilities patients' success in

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community discharge,[3,4] little is known about SNF patients' success in returning and staying home post-discharge.

SNF admission is often the gateway to becoming a long-term nursing home resident. And, Alzheimer Disease and Related Dementias (ADRD) patients are more likely to become long-stay residents. The Affordable Care Act (ACA) and other policy initiatives strongly encourage community based long-term care for ADRD patients.[5] In 2012, under the ACA the Centers for Medicare & Medicaid Services (CMS) could penalize hospitals for readmissions in less than 30 days for certain conditions. Successful transitioning from the hospital to a SNF is even more complicated for persons with ADRD. For example, patients with ADRD whose behavioral problems surpass the SNF's capacity to accommodate them are at high risk of rehospitalization or transfer to a different SNF.[6] For this reason, SNF administrators may be less likely to accept patients with ADRD after acute hospitalization. Indeed, one study reported that SNF personnel believe hospital personnel downplay ADRD patients' behavioral problems to increase their chances of SNF admission.[6] For these reasons, real and perceived about patients with ADRD, we hypothesized that Medicare beneficiaries with ADRD would experience more negative outcomes than those without ADRD, in terms of their likelihood of successfully returning home, experiencing rehospitalization, dying in the SNF, becoming a permanent nursing home resident, or transferring to another SNF, and we assessed whether the differences changed between 2007 and 2015.

METHODS

Study Population

Our sample was drawn from 100% of Medicare SNF claims linked to the CMS Minimum Data Set, which are mandatory clinical assessments for all nursing home residents of Medicare-certified nursing homes, from January 1, 2007 through September 30, 2015 (with follow-up for post-discharge outcomes dated through December 31, 2015). The study period was chosen to include only events occurring before the introduction of the ICD-10 coding system. We included fee-for-service Medicare beneficiaries aged ≥66 years who were discharged alive from the hospital and admitted to a SNF within 1 day of hospital discharge. We excluded those with history of being in a nursing home within the 12 months (using the MDS) before hospital admission because they were likely to be sicker and/or more severely demented.[7]

Main Exposure Measure

We identified Medicare beneficiaries with ADRD using the Chronic Condition Data Warehouse (CCW) flag in the Medicare beneficiary summary file as of the day of hospital discharge. The CCW algorithm identifies beneficiaries as having ADRD if they have one of 24 ICD-9 codes present on one or more inpatient, SNF, HHA, outpatient, or carrier claim over a 3-year look-back period.[8] This definition has a sensitivity (0.85) and specificity (0.89).[9] We believe this is sufficient to assess changes in trends because (1) the measure did not change during the study period (ICD-9 codes were used throughout) and (2) we hypothesized post-discharge outcomes of ADRD patients may differ from those without ADRD, in part due to perceptions of ADRD patients. In other words, regardless of truly having ADRD, if beneficiaries' have an ADRD diagnosis, then healthcare providers perceive that they have ADRD.

Outcome Measures

We assessed trends over our study period in seven outcome measures. First, we defined successful discharge as being discharged alive from a SNF to the community within 90 days of SNF admission without subsequent inpatient healthcare utilization for 30 continuous days. Second, we defined becoming a long-stay resident as remaining in the SNF more than 90 days after SNF admission. Third, we defined dying in the SNF as dying within 90 days of SNF admission. Fourth, we assessed death within 90 days after discharge from the SNF (after being in the SNF at least 90 days). We assessed rehospitalization two ways: within 30 days and within 90 of hospital discharge. For both rehospitalization measures, those who died in the same

Table 1. Characteristics of Medicare Beneficiaries Aged 66 years and Older with Hospital Discharge to Nursing Home

	January 1 to December 31, 2007		January 1 to December 31, 2011		January 1 to September 30, 2015	
	ADRD N = 211,518	No ADRD N = 406,667	ADRD N = 277,751	No ADRD N = 484,728	ADRD N = 217,990	No ADRD N = 370,702
Age, mean	84.1	80.5	84.5	80.3	84.6	80.0
Female (%)	67.0	67.7	66.5	66.9	64.9	64.9
Black (%)	8.0	6.2	8.4	6.6	8.6	6.9
Other race (%)	3.4	3.1	4.1	3.5	4.6	3.9
Dual eligible (%)	18.0	11.4	18.1	11.0	16.9	10.3
# of hospitalized days, mean	8.1	8.6	7.6	7.8	7.4	7.7
Residential ZIP code Medicare Advantage penetration, mean %	17.8	17.6	22.7	22.4	28.7	28.1
Residential ZIP code dual-eligible rate, mean %	13.0	12.5	13.1	12.5	12.7	12.2

Table 2. FFS Medicare Beneficiaries Aged >65 Years Discharged from Hospital to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 211,518	2008 N = 271,953	2009 N = 265,601	2010 N = 279,013	2011 N = 277,751	2012 N = 282,761	2013 N = 283,171	2014 N = 288,361	2015 N = 217,990
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.0 (1.8,2.2)	43.5%	44.1%	45.7%	46.5%	47.4%	48.3%	49.3%	50.1%	50.9%
Long-stay	−3.6 (−4.4, −2.8)	15.0%	14.2%	13.4%	12.5%	12.2%	11.8%	11.7%	11.3%	11.3%
Death in SNF	−0.7 (−1.1, −0.3)	16.9%	17.0%	16.2%	16.3%	16.1%	16.4%	16.2%	16.1%	15.8%
Death within 90 days of discharge from SNF	−0.2 (−1.0, 0.7)	8.9%	8.3%	8.2%	8.4%	8.4%	8.6%	8.4%	8.6%	8.2%
Re-entered hospital within 30 days	−2.8 (−3.6, −2.0)	16.0%	16.4%	16.1%	15.8%	15.3%	14.5%	13.8%	13.5%	13.4%
Re-entered hospital within 90 days	−1.7 (−2.3, −1.2)	27.4%	27.8%	27.4%	27.3%	26.6%	25.9%	24.8%	24.8%	24.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.3, −0.7)	5.0%	4.7%	4.5%	4.2%	4.2%	4.1%	4.1%	4.3%	4.3%
		N = 406,667	**N = 507,801**	**N = 497,452**	**N = 510,887**	**N = 484,728**	**N = 480,412**	**N = 488,342**	**N = 489,829**	**N = 370,702**
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.0 (0.8,1.2)	59.0%	58.6%	59.5%	60.1%	61.1%	61.8%	62.5%	62.7%	62.9%
Long-stay	−3.4 (−4.3, −2.6)	5.5%	5.3%	5.0%	4.8%	4.6%	4.4%	4.4%	4.3%	4.3%
Death in SNF	−1.4 (−1.8, −0.9)	13.9%	14.0%	13.5%	13.2%	12.9%	12.9%	12.8%	12.8%	12.8%
Death within 90 days of discharge from SNF	−1.1 (−1.5, −0.6)	6.3%	6.2%	6.1%	6.0%	5.9%	5.9%	5.7%	5.9%	5.7%
Re-entered hospital within 30 days	−2.9 (−3.6, −2.1)	16.5%	16.8%	16.4%	16.1%	15.5%	14.7%	14.0%	13.8%	13.9%
Re-entered hospital within 90 days	−2.1 (−2.7, −1.5)	26.8%	27.2%	26.7%	26.3%	25.5%	24.6%	23.6%	23.5%	23.6%
Patient was transferred from SNF to another facility within 30 days	−3.1 (−4.4, −1.8)	3.5%	3.3%	3.1%	2.9%	2.8%	2.7%	2.7%	2.7%	2.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

timeframe were censored. Finally, we assessed transfer to another NH within 30 days of entering the SNF. To clarify "SNF," our focus is not on SNF coverage for payment, but rather PAC in a SNF which is typically short-stay or ≤90 days. We used the sequence of claims and the MDS to identify outcomes.

Statistical Analyses

First, we assessed the overall change in number of beneficiaries with and without ADRD from 2007 to 2014 (for this we excluded 2015 because it was a partial year). Trends for each outcome were then assessed on annual cohorts of beneficiaries who were discharged from the hospital to a SNF, adjusting for age, sex, race, dual-eligibility, Medicare Advantage penetration (zipcode of residence), and percent dual-eligible (zipcode of residence). We used STATA version 16 software to obtain adjusted predictive margins and standard errors. We evaluated monotonic trends by joinpoint regression using Joinpoint software,[10] which has the same underlying assumptions as simple regression and allows for input of estimates and standard errors. To determine if the trend was statistically significant we used the average annual percent change (AAPC) and its associated *P*-value. We also compared AAPC differences in trends between those with and without ADRD. All analyses were stratified by beneficiary ADRD status.

Sensitivity Analyses

Because our analyses included all FFS beneficiaries discharged from the hospital to a SNF, we wanted to determine if results would be similar for a more homogenous group or if our findings were driven by certain subgroups. Therefore, we performed the same trend analyses for patients hospitalized for hip fractures and were discharged from the hospital to a SNF. Codes used to define hip fractures were 820.xx.

All analyses were conducted after establishing a data use agreement with CMS and obtaining final approval from Brown University's Institutional Review Board.

RESULTS

We identified 2,134,798 beneficiaries with prevalent ADRD (243,321 or 11.4% were included in multiple years) and 3,582,546 without (654,274 or 18.3% were included in multiple years) who otherwise met study eligibility criteria. The average age of beneficiaries with ADRD discharged from hospital to SNF was close to 84 years in 2007, 2011, and 2015; the average age of those without ADRD was approximately 80 years at the beginning, middle, and end of the study (Table 1). About two-thirds of those with and without ADRD were female. The average proportion with Medicare Advantage penetration in the residents' zip code increased from 2007 to 2015 for those with (17.8%–28.7%) and without ADRD (17.6%–28.1%). A few (7.4% n = 486,715) of beneficiaries were referred to a hospice within 90 days of entering the SNF or in the 90 days following SNF discharge; of those, 85.2% died.

The number of beneficiaries with ADRD discharged from the hospital to a SNF increased 36.3% from 211,518 in 2007 to 288,361 in 2014 (2015 was a partial year, AAPC = 3.1 (0.3, 5.9)). There was no significant change in the number of beneficiaries without ADRD discharged from the hospital to a SNF from 2007 to 2014 (AAPC = 1.1 (−1.6, 3.9)). The proportion of traditional Medicare beneficiaries with ADRD who had a successful discharge from the SNF to the community increased from 43.5% in 2007 to 50.9% in 2015 (AAPC = 2.0 (1.8, 2.2)) (Table 2 and Figure 1). Successful discharge for those without ADRD also increased (from 59.0% to 62.9%, AAPC = 1.0 (0.8, 1.2)), but not as fast as for those with ADRD (AAPC difference (ADRD − No ADRD) = 1.0 (0.8, 1.2), $P < .01$). The proportion of beneficiaries with ADRD who became long-stay nursing home residents decreased (from 15.0% in 2007 to 11.3% in 2015, AAPC = −3.6 (−4.4, −2.8)); those without ADRD decreased also (from 5.5% to 4.3%, AAPC = −3.4 (−4.3, −2.6)) similar to those with ADRD ($P = .70$). However, the proportion of those with ADRD who became long-stay was nearly three times higher than those without. The proportion of beneficiaries with ADRD who died within 90 days of entering the SNF decreased from 2007 (16.9%) to 2015 (15.8%, AAPC = −0.7 (−1.2, −0.2)); those without ADRD decreased as well from 13.9% in 2007 to 12.8% in 2015 (AAPC = −1.4 (−1.8, −0.9)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The proportion of beneficiaries with ADRD who died within 90 days of discharge from the SNF did not change from 2007 (8.9%) to 2015 (8.2%, $P = .7$); those without ADRD decreased from 6.3% in 2007 to 5.7% in 2015 (AAPC = −1.1 (−1.5, −0.6)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The

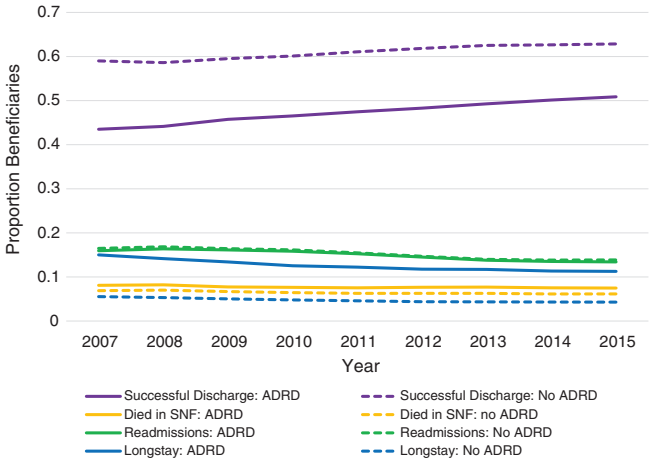

Figure 1. Adjusted proportion of FFS Medicare Beneficiaries aged >65 years discharged from hospital to SNF by ADRD status, January 1, 2007 through September 30, 2015. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. ADRD, Alzheimer's disease and related dementias; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; readmissions, readmitted to hospital within 30 days of entering SNF; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

Table 3. FFS Medicare Beneficiaries Aged >65 Years Hospitalized for Hip Fractures and Discharged to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 23,485	2008 N = 29,321	2009 N = 29,445	2010 N = 30,215	2011 N = 29,772	2012 N = 30,408	2013 N = 31,483	2014 N = 31,882	2015 N = 23,500
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.1 (1.8,2.4)	43.2%	44.0%	45.6%	46.1%	47.4%	47.6%	49.5%	50.6%	50.6%
Long-stay	−3.0 (−3.9, −2.1)	16.0%	14.7%	14.3%	13.5%	13.3%	12.9%	13.0%	12.3%	12.4%
Death in SNF	−1.4 (−2.2, −0.5)	16.1%	16.5%	14.8%	15.1%	14.9%	15.0%	14.7%	14.6%	14.5%
Death within 90 days of discharge from SNF	−0.2 (−1.2, 0.7)	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
Re-entered hospital within 30 days	−3.4 (−4.6, −2.3)	14.9%	15.6%	14.7%	14.9%	13.6%	13.2%	12.2%	12.0%	12.4%
Re-entered Hospital within 90 days	−2.3 (−3.3, −2.0)	23.8%	25.0%	24.2%	24.2%	22.8%	22.3%	20.9%	20.8%	21.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.7, −0.3)	6.8%	6.1%	5.9%	5.5%	5.4%	5.5%	5.4%	5.7%	5.6%
		N = 36,725	N = 44,544	N = 43,394	N = 44,026	N = 41,341	N = 40,683	N = 41,740	N = 42,804	N = 31,612
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.2 (1.1,1.4)	62.6%	62.9%	63.9%	63.9%	65.4%	65.8%	67.2%	67.7%	68.6%
Long-stay	−3.8 (−4.5, −3.0)	6.3%	5.8%	5.6%	5.4%	5.2%	5.0%	4.5%	4.7%	4.7%
Death in SNF	−2.9 (−3.7, −2.2)	9.2%	9.1%	8.8%	8.6%	7.8%	7.8%	7.7%	7.7%	7.3%
Death within 90 days of discharge from SNF	−1.5 (−2.7, −0.3)	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%
Re-entered hospital within 30 days	−3.2 (−4.1, −2.4)	13.1%	13.4%	12.9%	12.9%	12.2%	11.9%	11.1%	10.6%	10.5%
Re-entered hospital within 90 days	−2.7 (−3.3, −2.0)	21.9%	21.8%	21.3%	21.4%	20.5%	19.9%	18.5%	18.4%	18.2%
Patient was transferred from SNF to another facility within 30 days	−4.2 (−5.4, −3.0)	5.1%	4.8%	4.5%	4.1%	3.9%	3.9%	3.7%	3.7%	3.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

proportion of beneficiaries discharged and rehospitalized within 30 days and 90 days decreased among both those with (AAPC = −2.8 (−3.6, −2.0) and AAPC = −1.7 (−2.3, −1.2)) and without ADRD (APC = −2.9 (−3.6, −2.1) and AAPC = −2.1 (−2.7, −1.5)) during the study period, though not significantly different from each other (P = .90 and P = .20, respectively). The proportion of beneficiaries discharged to SNF and transferred to another nursing facility decreased among both those with ADRD from 5.0% to 4.3% (AAPC = −2.0 (−3.3, −0.7)) and without ADRD from 3.5% to 2.8% (AAPC = −3.1 (−4.4, −1.8)), though not significantly different from each other (P = .20).

Results of Sensitivity Analyses

Overall, 9.5% of patients discharged had claims for being hospitalized with hip fracture. The number of beneficiaries discharged from the hospital to a SNF increased 35.8% from 23,485 in 2007 to 31,882 in 2014 (2015 was a partial year and therefore excluded, AAPC = 3.1 (0.7, 5.6)). There was no significant change in beneficiaries without ADRD discharged from the hospital to a SNF (AAPC = 0.6 (−1.8, 3.1). Those hospitalized for hip fracture, with and without ADRD, experienced more successful SNF-to-community discharges after acute hospitalization, fewer deaths, rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF from 2007 to 2015 (P < .05) (Table 3). The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as rates of successful discharges increased faster among those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (0.6, 1.2)).

DISCUSSION

In general, traditional Medicare beneficiaries with ADRD have worse outcomes than those without ADRD, but the gap is narrowing with respect to returning home from the SNF, surviving and not being rehospitalized. From 2007 to 2015, Medicare beneficiaries experienced more successful SNF-to-community discharges after acute hospitalization, due to fewer rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF. The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as the rates of successful discharges increased faster among those with ADRD. Deaths within 90 days of discharge to SNF did not change among beneficiaries with ADRD, yet the mortality rate decreased among the non-ADRD group. Notably, the gap between those with and without ADRD in becoming long-stay remained; those with ADRD were nearly three times as likely to become long-stay residents.

Studies have reported an increase in the number of adults living with ADRD.[11] This is reflected in our study showing an increase in ADRD patients discharged from the hospital to the SNF overall and also in our sensitivity analysis among hospitalizations for hip fractures. Our results may indicate that the greater number of patients with ADRD discharged home may reflect healthier people being diagnosed with ADRD at earlier stages.

Higher rates of successful discharge from SNF to the community and fewer rehospitalizations, long-stays, and transfers to other nursing facilities among beneficiaries with ADRD over a decade are quite encouraging. Previous studies have reported persons with ADRD experience frequent transitions across the range of care, especially into and out of hospital and SNF settings.[12,13] And, nearly half of long-stay nursing home residents suffer from ADRD.[14,15] Our data suggest that the proportion of patients with ADRD who become long-stay residents after entering the SNF after being hospitalized is decreasing.

It is not surprising that rates of rehospitalization after hospital discharge to SNF decreased for all beneficiaries. In October 2012 a policy was mandated by the ACA to penalize hospitals with high readmission rates for certain conditions.[16] Readmission rates for some SNFs may have been high before 2012 because of the change in use of SNF care. Most SNFs (>90%) are dually certified as a SNF and as a nursing home.[17] Thus, a facility that offers skilled care often also provides long-term care services that Medicare does not cover. Ideally, SNF care is provided to restore function to patients discharged from acute hospital care before transitioning back to the community. In the decade before 2012, use of SNF care after acute hospitalization had greatly increased in part because of the shift of nursing homes from serving life long residents to facilities treating increasingly medically complex patients seeking PAC for recuperation after hospitalization. This may in part have been driven by a financial incentive to take advantage of the short-term Medicare benefit. Medicare covers up to 100 days after 3 days of hospitalization whereas Medicaid pays for most of long-term care, the Medicare payment for SNF services being higher than that for Medicaid. In other words, some patients may have been sent to the SNF as long as the financial benefit was available and then sent back to the hospital. Yet since the 2012 policy, that practice likely diminished.

Our result of decline in long-stay residents, with and without ADRD, helps to explain why occupancy in nursing homes continues to decline even though the number of beds has been steadily declining.[18-20] In nursing homes in states with no or nursing home-specific certificate-of-need programs (designed to curb healthcare spending), the number of beds has decreased since 1992.[21] The decline in long-stay residents may also be a reflection of the number of nursing home closures. Facilities with large proportions of long-stay residents tended to have high Medicaid occupancy,[22] and those facilities were most at risk of closure.[23]

Our study was subject to several limitations. First, discharge data for the Medicare Advantage population are not reliable and therefore were not included. Given the rapid growth of Medicare Advantage, which has a strong disincentive for hospital use, the results observed may not reflect the overall population aged 66 years and older. Second, the proportion of ADRD we reported likely includes some false-positive and false-negative ADRD cases; however, the CCW algorithm is the only approach that can identify a broad sample of beneficiaries with ADRD across community and nursing home settings in hospitalization data. Still, regardless of how ADRD is diagnosed, the trends reveal an increase in successful discharges but a steady gap in becoming long-stay residents with a nearly threefold risk among

those with ADRD. Third, we did not assess the geographic availability of PAC services; hence some patients may have been discharged to the community because of access rather than recovery. Fourth, we could not account for health beliefs, financial resources, availability of an appropriate caregiver (paid or unpaid), or cultural differences which may have influenced discharge to and remaining in the community. Finally, a potential limitation is that certain cohorts of beneficiaries discharged from the hospital to SNFs could have driven the results. However, sensitivity analyses confirmed overall results with a homogenous group. Among patients who had been hospitalized for hip fractures, trends for those with and without ADRD were in the same direction and the same estimates were statistically significant as were found for the overall group of beneficiaries with two exceptions.

We examined the trends in outcomes among Medicare beneficiaries discharged to SNF with and without a diagnosis of ADRD and found that many outcomes improved for all persons but that successful discharge rates, going home and remaining there, improved more rapidly for persons living with dementia than for persons without dementia. It may be that practices with regard to hospitalization may have influenced the trends in addition to practices in the SNF. Thus, more research is needed to understand what is driving the reduction in transfers, deaths, and long-stays among patients with ADRD discharged from hospital to SNF. In addition, the increase in successful SNF to community discharges stresses the increasing importance of community as the care setting for adults with ADRD.

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Conflict of Interest: BHB, MR, CK, and RMW have no conflicts of interest to report. VM receives compensation for his role as Chair of the Scientific Advisory Committee of naviHealth, a post-acute care convening company serving managed care companies and integrated hospital systems.

Author Contributions: VM and MR conceived and designed the study. BHB drafted the manuscript and did the statistical analyses. MR and CK obtained and compiled the data. All authors revised the report for intellectual content and contributed to the literature search. VM and RMW provided administrative, technical and material support.

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Tab 13 NF RUC Summary

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ISSUE: Nursing Facility

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
REC	99304	XXX	Initial nursing facility care, per day, for the evaluation and			0.050	0.042			1.50			36	6					25			5					
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
REC	99305	XXX	Initial nursing facility care, per day, for the evaluation and			0.059	0.045			2.50			55	10					35			10					
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
REC	99306	XXX	Initial nursing facility care, per day, for the evaluation and			0.057	0.044			3.50			80	15					50			15					
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
REC	99307	XXX	Subsequent nursing facility care, per day, for the evaluation			0.055	0.050			0.70			14	1					12			1					
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
REC	99308	XXX	Subsequent nursing facility care, per day, for the evaluation			0.061	0.048			1.30			27	5					18			4					

Tab 13 NF RUC Summary

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
15					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
47	1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
48	2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
49	CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
50	SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
51	REC	99309	XXX	Subsequent nursing facility care, per day, for the evaluation			0.051	0.041			1.92			47	7					30			10					
52																												
53	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
54	2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
55	CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
56	SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
57	REC	99310	XXX	Subsequent nursing facility care, per day, for the evaluation			0.050	0.040			2.80			70	10					45			15					
58																												
59		99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

Tab 13 NF RUC Summary

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ISSUE: Nursing Facility

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
AMDA	99304	XXX	Initial NF, PD, SF or low MDM	AMDA	112	0.056	0.045	0.70	1.48	1.65	2.00	30.00	36.5	7			0	20	25	31	120	5	0	0	5	15	750
AAPM&R	99304	XXX	Initial NF, PD, SF or low MDM	AAPM&R	15	0.072	0.059	0.93	1.60	2.00	2.55	3.50	34	4			10	20	25	30	60	5	0	0	0	16	75
ACP	99304	XXX	Initial NF, PD, SF or low MDM	ACP	7	0.079	0.060	0.93	1.34	1.80	2.35	2.75	30	5			5	19	20	25	35	5	0	0	5	8	100
AGS	99304	XXX	Initial NF, PD, SF or low MDM	AGS	41	0.049	0.040	0.50	1.60	1.80	2.60	4.00	45	10			0	20	30	30	120	5	0	0	0	4	300
ANA	99304	XXX	Initial NF, PD, SF or low MDM	ANA	1	0.013	0.017	0.95	0.95	0.95	0.95	0.95	55	10			30	30	30	30	30	15	0	0	0	0	0
APMA	99304	XXX	Initial NF, PD, SF or low MDM	APMA	27	0.044	0.037	0.75	1.50	1.60	1.75	2.60	43	5			10	20	30	30	48	8	0	0	0	20	1150
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
AMDA	99305	XXX	Initial NF, PD, moderate MDM	AMDA	125	0.055	0.044	0.95	2.35	2.66	3.00	4.00	60	10			6	30	40	45	180	10	0	5	28	100	962
AAPM&R	99305	XXX	Initial NF, PD, moderate MDM	AAPM&R	20	0.072	0.053	1.00	2.39	2.75	3.01	4.75	51.5	9			15	24	33	40	60	10	0	15	51	158	725
ACP	99305	XXX	Initial NF, PD, moderate MDM	ACP	9	0.081	0.060	1.92	2.60	2.80	2.90	3.75	47	7			10	30	30	30	50	10	0	7	20	100	520
AGS	99305	XXX	Initial NF, PD, moderate MDM	AGS	49	0.059	0.044	0.75	2.60	2.80	3.50	4.00	63	15			6	25	38	50	120	10	0	1	10	26	150
ANA	99305	XXX	Initial NF, PD, moderate MDM	ANA	1	0.023	0.023	1.60	1.60	1.60	1.60	1.60	70	10			45	45	45	45	45	15	0	0	0	0	0

Tab 13 NF RUC Summary

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
AMDA	99306	XXX	Initial NF, PD, High MDM	AMDA	125	0.061	0.047	1.30	3.50	3.72	4.00	5.00	80	15			9	40	50	65	340	15	0	12	57	150	1500
AAPM&R	99306	XXX	Initial NF, PD, High MDM	AAPM&R	20	0.075	0.058	1.00	3.08	3.65	3.84	5.90	62.5	10			20	30	43	53	60	10	0	10	50	193	500
ACP	99306	XXX	Initial NF, PD, High MDM	ACP	10	0.078	0.059	2.80	3.50	3.60	3.80	4.00	61	13			25	40	40	44	75	8	0	7	25	70	215
AGS	99306	XXX	Initial NF, PD, High MDM	AGS	52	0.050	0.040	1.00	3.23	3.80	4.07	5.00	95	20			10	35	60	71	120	15	0	5	40	100	432
ANA	99306	XXX	Initial NF, PD, High MDM	ANA	1	0.037	0.032	2.75	2.75	2.75	2.75	2.75	85	10			60	60	60	60	60	15	0	0	0	0	0
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and management of a patient,		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
AMDA	99307	XXX	Subsequent NF, PD, SF or low MDM	AMDA	123	0.071	0.071	0.18	0.70	0.85	1.30	2.80	12	0			3	10	12	15	60	0	0	2	19	50	2000
AAPM&R	99307	XXX	Subsequent NF, PD, SF or low MDM	AAPM&R	18	0.071	0.057	0.65	0.71	0.80	1.19	1.92	14	1			5	10	10	15	35	3	0	0	4	44	689
ACP	99307	XXX	Subsequent NF, PD, SF or low MDM	ACP	9	0.042	0.039	0.60	0.70	0.70	0.80	1.40	18	2			8	10	15	15	50	1	0	3	12	24	1000
AGS	99307	XXX	Subsequent NF, PD, SF or low MDM	AGS	45	0.066	0.053	0.50	0.80	0.90	1.30	4.00	17	3			0	10	12	15	120	2	0	0	2	15	3000
ANA	99307	XXX	Subsequent NF, PD, SF or low MDM	ANA	1	0.010	0.017	0.75	0.75	0.75	0.75	0.75	45	10			20	20	20	20	20	15	0	0	0	0	0

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
AMDA	99308	XXX	Subsequent NF, PD, Low level MDM	AMDA	129	0.065	0.054	0.70	1.30	1.40	1.92	3.60	26	3			5	15	19	25	90	4	0	33	114	400	2500
AAPM&R	99308	XXX	Subsequent NF, PD, Low level MDM	AAPM&R	23	0.084	0.067	0.70	1.20	1.40	1.50	1.98	21	3			3	10	15	18	35	3	0	18	400	1185	6000
ACP	99308	XXX	Subsequent NF, PD, Low level MDM	ACP	10	0.070	0.056	1.30	1.30	1.40	1.48	2.60	25	4			10	12	18	25	35	4	0	11	40	238	2000
AGS	99308	XXX	Subsequent NF, PD, Low level MDM	AGS	51	0.064	0.050	0.50	1.30	1.50	1.91	5.00	30	5			3	15	20	25	120	5	0	3	30	143	1000
ANA	99308	XXX	Subsequent NF, PD, Low level MDM	ANA	1	0.024	0.023	1.40	1.40	1.40	1.40	1.40	60	15			30	30	30	30	30	15	250	250	250	250	250
1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
AMDA	99309	XXX	Subsequent NF, PD, moderate MDM	AMDA	131	0.058	0.046	1.10	1.94	2.07	2.64	4.15	45	5			5	20	30	38	120	10	0	40	123	350	2000
AAPM&R	99309	XXX	Subsequent NF, PD, moderate MDM	AAPM&R	23	0.071	0.057	1.00	1.60	2.00	2.23	3.00	35	5			5	15	25	25	40	5	0	50	355	1000	2000
ACP	99309	XXX	Subsequent NF, PD, moderate MDM	ACP	10	0.070	0.054	1.92	1.96	2.05	2.53	2.80	38	7			15	20	25	33	40	6	0	9	24	198	750
AGS	99309	XXX	Subsequent NF, PD, moderate MDM	AGS	52	0.054	0.041	0.75	1.92	2.10	2.80	6.00	51	11			6	24	30	36	120	10	0	15	50	175	1476
ANA	99309	XXX	Subsequent NF, PD, moderate MDM	ANA	1	0.033	0.028	2.10	2.10	2.10	2.10	2.10	75	15			40	40	40	40	40	20	400	400	400	400	400
1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
AMDA	99310	XXX	Subsequent NF, PD, High MDM	AMDA	126	0.054	0.043	1.10	2.80	3.00	3.74	5.00	70	10			5	35	45	59	180	15	0	3	15	54	1500
AAPM&R	99310	XXX	Subsequent NF, PD, High MDM	AAPM&R	18	0.085	0.060	1.00	2.50	3.00	3.43	4.50	50	10			10	30	30	44	55	10	0	1	19	163	884
ACP	99310	XXX	Subsequent NF, PD, High MDM	ACP	9	0.080	0.059	2.80	2.80	3.00	3.20	4.00	51	10			20	30	32	45	60	9	0	0	3	25	45
AGS	99310	XXX	Subsequent NF, PD, High MDM	AGS	49	0.052	0.040	1.00	2.80	3.00	3.60	7.00	75	15			0	35	45	60	120	15	0	2	12	45	1200
ANA	99310	XXX	Subsequent NF, PD, High MDM	ANA	1	0.040	0.032	2.90	2.90	2.90	2.90	2.90	90	20			50	50	50	50	50	20	1500	1500	1500	1500	1500
1st REF	99495	XXX	Transitional Care Management Services with the following	2018-10	78	0.051	0.051			2.78			54						54								
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	33	0.051	0.041			1.92			47	7					30			10					
CURRENT	99315	XXX	Nursing facility discharge day management; 30 minutes or less	10/1/2010		0.042	0.032			1.28			40	10					20			10					
SVY	99315	XXX	Nursing facility discharge day management; 30 minutes or		185	0.071	0.053	0.50	1.50	2.10	2.78	8.00	40	10			0	20	25	30	125	5	0	0	10	28	450

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
AMDA	99315	XXX	NF Discharge Mgt 30 min or less	AMDA	124	0.069	0.051	0.70	1.50	2.05	2.78	4.50	40	10			0	17	25	30	60	5	0	1	10	25	450
AAPM&R	99315	XXX	NF Discharge Mgt 30 min or less	AAPM&R	10	0.081	0.056	1.00	1.41	1.96	2.21	2.78	35	8			0	13	20	29	30	8	0	0	0	13	75
ACP	99315	XXX	NF Discharge Mgt 30 min or less	ACP	8	0.071	0.059	0.93	3.00	1.95	2.78	3.00	33	5			15	19	25	26	40	3	0	4	24	73	210
AGS	99315	XXX	NF Discharge Mgt 30 min or less	AGS	42	0.071	0.054	0.50	1.93	2.52	3.00	8.00	47	12			10	20	30	34	125	5	0	0	2	30	300
ANA	99315	XXX	NF Discharge Mgt 30 min or less	ANA	1	0.111	0.058	2.90	2.90	2.90	2.90	2.90	50	30			20	20	20	20	20	0	0	0	0	0	0
1st REF	99496	XXX	Transitional Care Management Services with the following	2018-10	88	0.051	0.051			3.79			75						75								
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.050	0.040			2.80			70	10					45			15					
CURRENT	99316	XXX	Nursing facility discharge day management; more than 30 minutes	10/1/2010		0.050	0.035			1.90			54	14					25			15					
SVY	99316	XXX	Nursing facility discharge day management; more than 30		191	0.062	0.048	0.75	2.50	3.01	3.80	9.00	63	15			0	30	40	50	120	8	0	0	10	40	800
AMDA	99316	XXX	NF Discharge Mgt 30 min or more	AMDA	125	0.064	0.050	1.00	2.48	3.00	3.79	4.80	60	12			0	30	40	50	90	8	0	1	10	45	800
AAPM&R	99316	XXX	NF Discharge Mgt 30 min or more	AAPM&R	10	0.068	0.049	1.50	2.00	2.65	2.96	4.50	54	13			0	21	32	43	60	10	0	0	0	11	75
ACP	99316	XXX	NF Discharge Mgt 30 min or more	ACP	10	0.070	0.054	1.60	2.19	3.30	3.83	4.50	61.5	14			22	35	40	48	50	8	0	1	8	34	200
AGS	99316	XXX	NF Discharge Mgt 30 min or more	AGS	45	0.065	0.049	0.75	2.95	3.50	3.99	9.00	71	16			10	35	45	55	120	10	0	0	9	37	300
ANA	99316	XXX	NF Discharge Mgt 30 min or more	ANA	1	0.089	0.044	4.00	4.00	4.00	4.00	4.00	90	60			30	30	30	30	30	0	30	30	30	30	30
	99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

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ISSUE: Nursing Facility (*Medical Specialty Details*)

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
Geriatric Medicine & Hospice and Paliative Medicine	99304	XXX	Initial NF, PD, SF or low MDM	Geriatric Medicine & Hospice and Paliative Medicine	97	0.051	0.043	0.50	1.60	1.80	2.15	4.00	42	7			3	20	30	35	120	5	0	0	2	10	150
IM & FM	99304	XXX	Initial NF, PD, SF or low MDM	IM & FM	59	0.054	0.043	0.70	1.21	1.64	2.00	3.25	38	8			0	15	25	30	120	5	0	0	5	20	750
NP & PA	99304	XXX	Initial NF, PD, SF or low MDM	NP & PA	3	0.012	0.017	0.93	0.93	0.93	15.47	30.00	55	20			5	18	30	38	45	5	0	10	20	160	300
Other, Ped and	99304	XXX	Initial NF, PD, SF or low MDM	Other, Ped and	2	0.046	0.036	1.50	1.53	1.55	1.58	1.60	42.5	10			25	25	25	25	25	8	6	30	53	77	100
PM&R	99304	XXX	Initial NF, PD, SF or low MDM	PM&R	16	0.069	0.058	0.93	1.60	1.90	2.53	3.50	32.5	4			7	20	25	30	60	4	0	0	0	13	75
Podiatry	99304	XXX	Initial NF, PD, SF or low MDM	Podiatry	26	0.044	0.038	0.75	1.50	1.60	1.78	2.60	42	5			10	20	30	30	48	7	0	0	0	19	1150
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
Geriatric Medicine & Hospice and Paliative Medicine	99305	XXX	Initial NF, PD, moderate MDM	Geriatric Medicine & Hospice and Paliative Medicine	109	0.058	0.046	0.75	2.60	2.80	3.00	4.00	61	11			6	30	40	52	120	10	0	5	15	50	962
IM & FM	99305	XXX	Initial NF, PD, moderate MDM	IM & FM	71	0.063	0.048	1.00	1.92	2.65	2.93	4.00	55	10			10	25	35	45	180	10	0	4	40	100	600
NP & PA	99305	XXX	Initial NF, PD, moderate MDM	NP & PA	2	0.054	0.038	1.60	1.85	2.10	2.35	2.60	55	18			10	19	28	36	45	10	0	38	75	113	150
Other, Ped and	99305	XXX	Initial NF, PD, moderate MDM	Other, Ped and	1	0.053	0.046	2.43	2.43	2.43	2.43	2.43	53	3			40	40	40	40	40	10	6	6	6	6	6
PM&R	99305	XXX	Initial NF, PD, moderate MDM	PM&R	21	0.080	0.061	1.00	2.35	2.75	3.00	4.75	45	8			10	20	30	40	60	7	0	15	48	150	725

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
Geriatric Medicine & Hospice and Paliative Medicine	99306	XXX	Initial NF, PD, High MDM	Geriatric Medicine & Hospice and Paliative Medicine	113	0.056	0.044	1.00	3.50	3.75	4.00	5.00	85	15			9	40	55	75	150	15	0	10	48	100	600
IM & FM	99306	XXX	Initial NF, PD, High MDM	IM & FM	71	0.069	0.051	1.50	3.13	3.75	4.00	5.00	74	14			15	35	45	60	340	15	0	10	58	200	1500
NP & PA	99306	XXX	Initial NF, PD, High MDM	NP & PA	2	0.074	0.050	3.50	3.50	3.50	3.50	3.50	70	25			15	26	38	49	60	8	0	38	75	113	150
Other, Ped and	99306	XXX	Initial NF, PD, High MDM	Other, Ped and	1	0.050	0.047	3.17	3.17	3.17	3.17	3.17	68	3			60	60	60	60	60	5	12	12	12	12	12
PM&R	99306	XXX	Initial NF, PD, High MDM	PM&R	21	0.079	0.060	1.00	3.10	3.60	3.79	5.90	60	10			15	30	40	50	60	10	0	0	50	191	500
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and management of a patient.		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
Geriatric Medicine & Hospice and Paliative Medicine	99307	XXX	Subsequent NF, PD, SF or low MDM	Geriatric Medicine & Hospice and Paliative Medicine	103	0.065	0.062	0.50	0.70	0.80	1.30	4.00	13	1			0	10	12	15	120	0	0	0	10	30	3000
IM & FM	99307	XXX	Subsequent NF, PD, SF or low MDM	IM & FM	70	0.054	0.049	0.18	0.70	0.88	1.30	2.80	18	1			0	10	15	17	60	2	0	2	20	60	2000
NP & PA	99307	XXX	Subsequent NF, PD, SF or low MDM	NP & PA	3	0.051	0.034	0.70	0.78	0.85	1.07	1.29	25	10			5	8	10	13	15	5	0	3	5	15	25
Other, Ped and	99307	XXX	Subsequent NF, PD, SF or low MDM	Other, Ped and	1	0.096	0.096	0.48	0.48	0.48	0.48	0.48	5	0			5	5	5	5	5	0	25	25	25	25	25
PM&R	99307	XXX	Subsequent NF, PD, SF or low MDM	PM&R	19	0.073	0.062	0.65	0.73	0.80	1.18	1.92	13	1			4	9	10	15	35	2	0	0	3	38	689

Tab 13 NF RUC Summary

Updated: 5/24/20224:54 PM

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
Geriatric Medicine & Hospice and Paliative Medicine	99308	XXX	Subsequent NF, PD, Low level MDM	Geriatric Medicine & Hospice and Paliative Medicine	112	0.061	0.048	0.50	1.30	1.41	1.87	5.00	29.5	5			3	15	20	25	120	5	0	11	60	200	2000
IM & FM	99308	XXX	Subsequent NF, PD, Low level MDM	IM & FM	74	0.064	0.053	0.70	1.30	1.45	1.92	2.75	27.5	4			5	15	20	25	90	4	0	40	200	500	2500
NP & PA	99308	XXX	Subsequent NF, PD, Low level MDM	NP & PA	5	0.124	0.082	0.93	1.30	1.40	1.50	2.05	17	3			3	10	10	14	20	4	180	300	750	791	5000
Other, Ped and	99308	XXX	Subsequent NF, PD, Low level MDM	Other, Ped and	1	0.088	0.069	0.97	0.97	0.97	0.97	0.97	14	2			10	10	10	10	10	2	100	100	100	100	100
PM&R	99308	XXX	Subsequent NF, PD, Low level MDM	PM&R	22	0.085	0.066	0.70	1.21	1.43	1.50	1.98	21.5	4			7	10	15	19	35	3	0	6	350	815	6000
1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
Geriatric Medicine & Hospice and Paliative Medicine	99309	XXX	Subsequent NF, PD, moderate MDM	Geriatric Medicine & Hospice and Paliative Medicine	114	0.056	0.043	0.75	1.95	2.10	2.80	6.00	49	9			6	24	30	40	120	10	0	20	78	300	2000
IM & FM	99309	XXX	Subsequent NF, PD, moderate MDM	IM & FM	75	0.063	0.049	1.10	1.92	2.10	2.59	3.60	43	5			5	20	28	37	120	10	0	55	156	350	2000
NP & PA	99309	XXX	Subsequent NF, PD, moderate MDM	NP & PA	5	0.097	0.051	1.60	1.92	2.02	2.20	2.67	40	15			5	10	15	25	30	10	48	400	1513	1560	1700
Other, Ped and	99309	XXX	Subsequent NF, PD, moderate MDM	Other, Ped and	1	0.076	0.063	1.25	1.25	1.25	1.25	1.25	20	3			15	15	15	15	15	2	60	60	60	60	60
PM&R	99309	XXX	Subsequent NF, PD, moderate MDM	PM&R	22	0.071	0.057	1.00	1.63	2.00	2.25	3.00	35	5			9	15	25	25	40	5	0	50	180	768	2000
1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
Geriatric Medicine & Hospice and Paliative Medicine	99310	XXX	Subsequent NF, PD, High MDM	Geriatric Medicine & Hospice and Paliative Medicine	109	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			10	35	45	60	120	15	0	3	15	48	1200
IM & FM	99310	XXX	Subsequent NF, PD, High MDM	IM & FM	71	0.057	0.045	1.10	2.80	3.00	3.50	4.87	66	9			0	30	44	50	180	13	0	2	14	60	1500
NP & PA	99310	XXX	Subsequent NF, PD, High MDM	NP & PA	5	0.075	0.049	2.80	2.80	2.90	3.50	3.95	59	15			10	15	30	30	55	14	6	25	150	533	884
Other, Ped and	99310	XXX	Subsequent NF, PD, High MDM	Other, Ped and	1	0.071	0.057	2.00	2.00	2.00	2.00	2.00	35	5			25	25	25	25	25	5	12	12	12	12	12
PM&R	99310	XXX	Subsequent NF, PD, High MDM	PM&R	17	0.073	0.055	1.00	2.40	3.00	3.92	5.00	55	10			18	30	35	45	55	10	0	0	5	30	500

Tab 13 NF RUC Summary

Updated: 5/24/20224:54 PM

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99495	XXX	Transitional Care Management Services with the following	2018-10	78	0.051	0.051			2.78			54						54									
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	33	0.051	0.041			1.92			47	7					30			10					
CURRENT	99315	XXX	Nursing facility discharge day management; 30 minutes or less	10/1/2010		0.042	0.032			1.28			40	10					20			10					
SVY	99315	XXX	Nursing facility discharge day management; 30 minutes or		185	0.071	0.053	0.50	1.50	2.10	2.78	8.00	40	10			0	20	25	30	125	5	0	0	10	28	450
Geriatric Medicine & Hospice and Paliative	99315	XXX	NF Discharge Mgt 30 min or less	Geriatric Medicine & Hospice and Paliative	101	0.080	0.060	0.50	1.80	2.50	2.80	8.00	42	10			5	20	27	30	120	5	0	0	6	22	300
IM & FM	99315	XXX	NF Discharge Mgt 30 min or less	IM & FM	69	0.071	0.057	0.93	1.50	2.00	2.78	3.80	35	10			0	20	25	30	125	0	0	1	10	50	300
NP & PA	99315	XXX	NF Discharge Mgt 30 min or less	NP & PA	3	0.158	0.077	1.40	3.00	1.92	2.27	2.61	25	10			10	10	10	13	15	5	2	14	25	238	450
Other, Ped and	99315	XXX	NF Discharge Mgt 30 min or less	Other, Ped and	1	0.053	0.050	1.50	1.50	1.50	1.50	1.50	30	3			27	27	27	27	27	0	6	6	6	6	6
PM&R	99315	XXX	NF Discharge Mgt 30 min or less	PM&R	11	0.078	0.050	1.00	1.53	2.00	2.43	3.50	40	10			0	15	20	28	30	10	0	0	0	10	75
1st REF	99496	XXX	Transitional Care Management Services with the following	2018-10	88	0.051	0.051			3.79			75						75								
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.050	0.040			2.80			70	10					45			15					
CURRENT	99316	XXX	Nursing facility discharge day management; more than 30 minutes	10/1/2010		0.050	0.035			1.90			54	14					25			15					
SVY	99316	XXX	Nursing facility discharge day management; more than 30		191	0.062	0.048	0.75	2.50	3.01	3.80	9.00	63	15			0	30	40	50	120	8	0	0	10	40	800
Geriatric Medicine & Hospice and Paliative Medicine	99316	XXX	NF Discharge Mgt 30 min or more	Geriatric Medicine & Hospice and Paliative Medicine	107	0.065	0.050	0.75	2.69	3.50	3.83	9.00	70	15			10	34	45	55	120	10	0	0	10	40	400
IM & FM	99316	XXX	NF Discharge Mgt 30 min or more	IM & FM	69	0.067	0.055	1.00	2.35	3.00	3.79	4.80	55	12			0	30	40	45	90	3	0	0	5	40	300
NP & PA	99316	XXX	NF Discharge Mgt 30 min or more	NP & PA	3	0.245	0.097	2.80	2.85	2.90	3.40	3.90	30	15			10	10	10	20	30	5	72	236	400	600	800
Other, Ped and	99316	XXX	NF Discharge Mgt 30 min or more	Other, Ped and	1	0.045	0.044	2.11	2.11	2.11	2.11	2.11	48	3			45	45	45	45	45	0	0	0	0	0	0
PM&R	99316	XXX	NF Discharge Mgt 30 min or more	PM&R	11	0.078	0.056	1.50	2.00	2.80	3.26	4.50	50	10			0	23	30	40	60	10	0	0	0	8	75
	99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

FACILITY DIRECT PE INPUTS **CPT CODE(S):99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April, 2021

CPT Code	Long Descriptor	Global Period
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99304	Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.
99305	Initial nursing facility visit for a patient with recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.
99306	Initial nursing facility visit for patient with multiple morbidities requiring intensive management
99307	Subsequent nursing facility visit for a patient with a self-limited or minor problem

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

99308	Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.
99309	Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment.
99310	Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2005 (99304-99310) were used as reference.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   Pre-Service
   All codes include time for an activity described in 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription.
   Several codes, specifically 99308, 99309 and 99310, include time for an activity described in the 2005 PE spreadsheets a "review/read x-ray, lab and pathology reports." This has been rolled into CA006 Confirm availability of prior images/studies.

Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99304-99310 included time for an activity described in the 2005 PE spreadsheet as "review/read x-ray, lab, and pathology reports" as well as "respond to consultant pharmacist or nutritionist reviews and recommendations" and "monitoring patient/notifying physician of change in condition" which have all be rolled into CA038 Coordinate post-procedure services.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99304	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99305	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99306	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99307	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99308	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99309	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99310	**CA005 6 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.

	CA006 3 minutes Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.

b. Service period (includes pre, intra and post):

c. Post-service period:

99304	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99305	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99306	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99307	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99308	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

99309	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99310	**CA037 6 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NON-FACILITY DIRECT PE INPUTS **CPT CODE(S):__99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA_

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April, 2021

CPT Code	Long Descriptor	Global Period
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99304	Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.
99305	Initial nursing facility visit for a patient with recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.
99306	Initial nursing facility visit for patient with multiple morbidities requiring intensive management
99307	Subsequent nursing facility visit for a patient with a self-limited or minor problem

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99308	Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.
99309	Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment.
99310	Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2005 (99304-99310) were used as reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Non-Facility Dominant Specialties

99304	Non-Facility Dominant Specialties – podiatry (31.4%), family medicine (17%) and nurse practitioner (13.5%)
99305	Non-Facility Dominant Specialties – internal medicine (23.6%), nurse practitioner (22.6%), family medicine (19.2%)
99306	Non-Facility Dominant Specialties – internal medicine (38.9%), family medicine (19.1%) and nurse practitioner (17.2%)
99307	Non-Facility Dominant Specialties – podiatry (22.4%), nurse practitioner (20.9%), family medicine (19.1%), internal medicine (17.4%)
99308	Non-Facility Dominant Specialties – nurse practitioner (41.5%), internal medicine (19.1%), family medicine (15.5%)

99309	Non-Facility Dominant Specialties – nurse practitioner (48.4%), internal medicine (18.8%), family medicine (14%)
99310	Non-Facility Dominant Specialties – nurse practitioner (49.5%), internal medicine (17.3%), family medicine (12.9%)

There are small differences in the percentages and order of the dominant specialties when comparing non-facility to global dominant specialties.

Global Dominant Specialties

99304	Non-Facility Dominant Specialties – podiatry (22.8%), family medicine (18.4%) and internal medicine (12.5%)
99305	Non-Facility Dominant Specialties – internal medicine (29.8%), family medicine (19.3%), nurse practitioner (13.8%)
99306	Non-Facility Dominant Specialties – internal medicine (42.6%), family medicine (19.5%) and nurse practitioner (9.8%)
99307	Non-Facility Dominant Specialties –nurse practitioner (24.8%), family medicine (19.1%), internal medicine (17.4%)
99308	Non-Facility Dominant Specialties – nurse practitioner (37.5%), internal medicine (22.1%), family medicine (13%)
99309	Non-Facility Dominant Specialties – nurse practitioner (45.3%), internal medicine (21.6%), family medicine (12%)
99310	Non-Facility Dominant Specialties – nurse practitioner (50.2%), internal medicine (18.8%), family medicine (10.6%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Pre-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription.
Several codes, specifically 99308, 99309 and 99310, include time for an activity described in the 2005 PE spreadsheets a "review/read x-ray, lab and pathology reports." This has been rolled into CA006 Confirm availability of prior images/studies.

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Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99304-99310 included time for an activity described in the 2005 PE spreadsheet as "review/read x-ray, lab, and pathology reports" as well as "respond to consultant pharmacist or nutritionist reviews and recommendations" and "monitoring patient/notifying physician of change in condition" which have all be rolled into CA038 Coordinate post-procedure services.

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99304	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99305	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99306	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99307	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99308	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99309	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes**

	Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99310	**CA005 6 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.

b. Service period (includes pre, intra and post):

c. Post-service period:

99304	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99305	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99306	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99307	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99308	**CA037 3 minutes**

	Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99309	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99310	**CA037 6 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

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INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?
    N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    N/A

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 99304**		**CPT Code 99304**		**CPT Code 99305**	
3		***RUC Collaboration Website***				Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D								
16	CA002		L037D								
17	CA003		L037D								
18	CA004		L037D								
19	CA005		L037D			3	3	3	3	3	3
20	CA006		L037D								
21	CA007		L037D								
22	CA008		L037D								
23			L037D								
26		*Other activity: please include short clinical description here and type*	L037D								
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009		L037D								
34	CA010		L037D								
35	CA011		L037D								
36	CA012		L037D								
37	CA013		L037D								
38	CA014		L037D								
39	CA015		L037D								
40	CA016		L037D								
41	CA017		L037D								
42			L037D								
45		*Other activity: please include short clinical description here and type*	L037D								
48		**Intra-service (of service period)**									
49	CA018		L037D								
50	CA019		L037D								
51	CA020		L037D								
52	CA021		L037D								
55			L037D								
56		*Other activity: please include short clinical description here and type*	L037D								
59		**Post-Service (of service period)**									
60	CA022		L037D								
61	CA023		L037D								
62	CA024		L037D								
63	CA025		L037D								
64	CA026		L037D								
65	CA027		L037D								
66	CA028		L037D								
67	CA029		L037D								
68	CA030		L037D								
69	CA031		L037D								
70	CA032		L037D								
71	CA033		L037D								
72	CA034		L037D								
73	CA035		L037D								
74	CA036		L037D			**n/a**		**n/a**		**n/a**	
75			L037D								
78		*Other activity: please include short clinical description here and type*	L037D								
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037		L037D			3	3	3	3	3	3
85	CA038		L037D			8	8	8	8	8	8
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D								
96		*Other activity: please include short clinical description here and type*	L037D								
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 99304**		**CPT Code 99304**		**CPT Code 99305**	
3		***RUC Collaboration Website***				Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102											
103											
104											
105											
106											
107											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112											
113											
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99305**		**CPT Code 99306**		**CPT Code 99306**		**CPT Code 99307**		**CPT Code 99307**	
3		***RUC Collaboration Website***	Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**11.0**	**11.0**	**11.0**	**11.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**8.0**	**8.0**	**8.0**	**8.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		3	3	3	3	3	3	3	3	3	3
20	CA006											
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		3	3	3	3	3	3	3	3	3	3
85	CA038		8	8	8	8	8	8	5	5	5	5
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99305**		**CPT Code 99306**		**CPT Code 99306**		**CPT Code 99307**		**CPT Code 99307**	
3		***RUC Collaboration Website***	Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**11.0**	**11.0**	**11.0**	**11.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**8.0**	**8.0**	**8.0**	**8.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**CPT Code 99308**		**CPT Code 99308**		**CPT Code 99309**		**CPT Code 99309**		**CPT Code 99310**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**17.0**	**17.0**	**17.0**	**17.0**	**21.0**	**21.0**	**21.0**	**21.0**	**27.0**	**27.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**9.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**15.0**	**15.0**	**15.0**	**15.0**	**18.0**	**18.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		3	3	3	3	3	3	3	3	6	6
20	CA006		3	3	3	3	3	3	3	3	3	3
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		3	3	3	3	3	3	3	3	6	6
85	CA038		8	8	8	8	12	12	12	12	12	12
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**CPT Code 99308**		**CPT Code 99308**		**CPT Code 99309**		**CPT Code 99309**		**CPT Code 99310**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**17.0**	**17.0**	**17.0**	**17.0**	**21.0**	**21.0**	**21.0**	**21.0**	**27.0**	**27.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**9.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**15.0**	**15.0**	**15.0**	**15.0**	**18.0**	**18.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99310**		**CPT Code 99315**		**CPT Code 99315**		**CPT Code 99316**		**CPT Code 99316**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; more than 30 minutes		Nursing facility discharge day mangement; more than 30 minutes	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**27.0**	**27.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**18.0**	**18.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		6	6	3	3	3	3	3	3	3	3
20	CA006		3	3								
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		6	6	3	3	3	3	3	3	3	3
85	CA038		12	12	6	6	6	6	6	6	6	6
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99310**		**CPT Code 99315**		**CPT Code 99315**		**CPT Code 99316**		**CPT Code 99316**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; more than 30 minutes		Nursing facility discharge day mangement; more than 30 minutes	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**27.0**	**27.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**18.0**	**18.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Home and Residence Services – Tab 14

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted twelve of the domiciliary, rest home (e.g., boarding home) and custodial care services to merge these services with the home visit services. The eight revised codes describe home and residence services to align with the principles included in the office or other outpatient E/M office visits by documenting and selecting level of service based on total time or medical decision making.

In April 2021, the specialty societies surveyed the eight home and residence codes but did not obtain the required number of survey responses for the established patients (99347, 99348, 99349 and 99350). More importantly, responses from the predominant provider, such as nurse practitioners, for some of the services was not achieved (99344, 99345, 99349 and 99350). The specialty societies intend to work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify qualified healthcare professionals, focusing on nurse practitioners, who predominantly perform home visit services and match them with societies to survey those individuals. The specialty societies also would like to ask the Research Subcommittee if it would be possible to limit the additional surveys to focus on obtaining valid responses and from the predominant providers (99344-99450).

The RUC recommends that the home and residence services be postponed until October 2021, and the specialty societies work with the Research Subcommittee to obtain valid and representative responses.

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services** ~~The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. These codes include evaluation and management services provided in an assisted living facility, group home, custodial care, and intermediate care facilities.~~ ~~The facility's services do not include a medical component.~~ ~~For definitions of key components and commonly used terms, please see **Evaluation and Management Services Guidelines.**~~ ~~(For care plan oversight services provided to a patient in a domiciliary facility under the care of a home health agency, see 99374, 99375, and for hospice agency, see 99377, 99378. For care plan oversight provided to a patient not under hospice or home health agency care, see 99339, 99340)~~ **New Patient** (99324, 99325, 99326, 99327, 99328 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, new patient, see home and residence services codes 99341, 99342, 99344, 99345)				

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~~99324~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ ~~• **A problem focused history;**~~ ~~• **A problem focused examination; and**~~ ~~• **Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~
~~99325~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ ~~• **An expanded problem focused history;**~~ ~~• **An expanded problem focused examination; and**~~ ~~• **Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~

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~~99326~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~
~~99327~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~

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~~99328~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~
Established Patient (99334, 99335, 99336, 99337 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, established patient, see home and residence services codes 99347, 99348, 99349, 99350)				
~~99334~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination;**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~

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~~99335~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • **~~An expanded problem focused history;~~** • **~~An expanded problem focused examination;~~** • **~~Medical decision making of low complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~
~~99336~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • **~~A detailed interval history;~~** • **~~A detailed examination;~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~

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~~99337~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of moderate to high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~
Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services ~~(For instructions on the use of 99339, 99340, see introductory notes for 99374-99380)~~ ~~(For care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility, see 99374-99380)~~ ~~(Do not report 99339, 99340 for time reported with 98966, 98967, 98968, 99421, 99422, 99423, 99441,99442, 99443)~~ (99339, 99340 have been deleted. For domiciliary, rest home [eg, assisted living facility], or home care plan oversight services, see Care Management Services codes 99491, 99X21, or Principal Care Management codes 99X22, 99X23)				
~~99339~~	-	~~Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes~~	~~XXX~~	~~N/A~~

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~~99340~~	-	~~30 minutes or more~~ ~~(Do not report 99339, 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents)~~ ~~(Do not report 99339, 99340 during the same month with 99487-99489)~~	~~XXX~~	~~N/A~~

Home and Residence Services

The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship).

For definitions of ~~key components and~~ commonly used terms, ~~please~~ see **Evaluation and Management Services Guidelines.**

~~(For care plan oversight services provided to a patient in the home under the care of a home health agency, see 99374, 99375, and for hospice agency, see 99377, 99378. For care plan oversight provided to a patient under hospice or home health agency care, see 99339, 99340)~~

These codes are also used when the residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

For services in an intermediate care facility for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, see **Nursing Facility Services**.

When selecting code level using time, do not count any travel time.

To report services when a patient is admitted to hospital inpatient, observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient and Observation Care** or **Initial Nursing Facility Care**.

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New Patient				
▲99341	J1	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~these 3 key components:~~ ~~• **A problem focused history;**~~ ~~• **A problem focused examination; and**~~ ~~• **Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Postpone until October 2021 (2021 work RVU = 1.01)
▲99342	J2	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~these 3 key components:~~ ~~• **An expanded problem focused history;**~~ ~~• **An expanded problem focused examination; and**~~ ~~• **Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Postpone until October 2021 (2021 work RVU = 1.52)

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~~99343~~	-	~~**Home visit** for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.~~ (99343 has been deleted. To report, see 99341, 99342, 99344, 99345)	~~XXX~~	~~N/A~~
▲99344	J3	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Postpone until October 2021 (2021 work RVU = 3.38)

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▲99345	J4	**Home <u>or residence</u> visit** for the evaluation and management of a new patient, which requires <u>a medically appropriate history and/or examination and high level of medical decision making.</u> ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u> <u>(For services ZZ minutes or longer, see prolonged services code 99417)</u>	XXX	Postpone until October 2021 (2021 work RVU = 4.09)
Established Patient				
▲99347	J5	**Home <u>or residence</u> visit** for the evaluation and management of an established patient, which requires <u>a medically appropriate history and/or examination straightforward medical decision making.</u> ~~at least 2 of these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u>	XXX	Postpone until October 2021 (2021 work RVU = 1.00)

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▲99348	J6	**Home <u>or residence</u> visit** for the evaluation and management of an established patient, which requires <u>a medically appropriate history and/or examination and low level of medical decision making.</u> ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u>	XXX	Postpone until October 2021 (2021 work RVU = 1.56)
▲99349	J7	**Home <u>or residence</u> visit** for the evaluation and management of an established patient, which requires <u>a medically appropriate history and/or examination and moderate level of medical decision making.</u> ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u>	XXX	Postpone until October 2021 (2021 work RVU = 2.33)

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▲99350	J8	**Home <u>or residence</u> visit** for the evaluation and management of an established patient, which requires <u>a medically appropriate history and/or examination and high level of medical decision making.</u> ~~at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of moderate to high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u> <u>(For services ZZ minutes or longer, see prolonged service code 99417)</u>	XXX	Postpone until October 2021 (2021 work RVU = 3.28)

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Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
330 North Wabash, Office 45-372
Chicago, IL 60611

March 26, 2021

RE: Home and Residence Services (Tab 14) CPT 2023

Dear Dr. Silva,

The undersigned medical societies submitted an LOI of 1 for the revised home visit codes. We have kept the survey open as long as we could in order to get as many responses as possible. However, we did not reach our required minimum for all the codes in time to send summary data to the RUC by the deadline. As you can see, in spite of our best efforts, which included daily, RUC approved, reminders to surveyees, (as well as adding more potential surveyees) we have been unable to obtain the required number of responses for the subsequent home visit codes.

More important, the breakout of completed responses not date, for some of these codes are missing the predominant users, the nurse practitioners (NP).

Data as of 3-24-2021	Code 1 99341	Code 2 99342	Code 3 99344	Code 4 99345	Code 5 99347	Code 6 99348	Code 7 99349	Code 8 99350
Total Responses	51	53	38	39	43	43	41	41
Required Responses	30	30	30	30	50	50	75	50
# to achieve valid	-21	-23	-8	-9	7	7	34	9
Predominant User	Podiatry	Podiatry	NP	NP	Podiatry	Podiatry	NP	NP
% in RUC database	87%	77%	52%	55%	72%	40%	50%	55%

The undersigned societies believe it is imperative that all eight codes be presented to the RUC at the same time. Therefore, we are writing to request more time so we can reach the required number of responses and to focus on the predominant users the nurse practitioners. We are not sure how long that will take but we do have a proposal that should maximize our chance for success. Specifically, we would like to use the Medicare Claims database to identify QHPs focusing on nurse practitioners who predominantly perform home visit services and match them with societies and ask the Research Committee if we can send the survey to those individuals. We need time to review this targeted list against our member lists. We also would like to ask the Research Committee if it would be possible to limit the additional surveys to the four subsequent visit codes or to two of the new services codes and either two or four of the subsequent codes again focusing on the predominant users, Nurse Practitioners, Family Medicine and Internal Medicine. We look forward to successfully completing these surveys and presenting to the RUC in October.

Sincerely,

American Geriatrics Society

American Nurses Association

American Podiatric Medical Association

American Academy of Home Care Medicine

Attachment: Survey data as of March 24, 2021

Preliminary Survey Data- as of 3-24-2021 Survey Remains Open

Discussion with research committee pending
Updated: 3/26/20212:44 PM

ISSUE: Home & Residency

TAB: 14 AGS, AAHCM, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new		23	0.055	0.047			0.93			20	2					15			3					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new		16	0.055	0.046			1.60			35	5					25			5					
CURRENT	99341	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997		0.033	0.028			1.01			36	6					20			10					
SVY	99341	XXX	Home or residence visit for the evaluation and management of a new		51	0.047	0.039	0.80	1.00	1.30	1.80	4.00	33	5			1	14	23	40	60	5	0	0	0	3	30
Physicians	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which		28	0.044	0.037	0.80	1.10	1.60	1.80	4.00	43	8			1	16	30	40	60	5	0	0	0	1	20
Podiatrists	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which		22	0.051	0.041	0.93	0.98	1.08	1.46	2.40	26	4			1	13	18	25	45	5	0	0	0	5	30
Nurse Practioners	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which		1	0.052	0.040	3.00	3.00	3.00	3.00	3.00	75	15			45	45	45	45	45	15	0	0	0	0	0
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and		30	0.055	0.046			1.60			35	5					25			5					
2nd REF	99204	XXX	Office or other outpatient visit for the evaluation and		13	0.054	0.043			2.60			60	10					40			10					
CURRENT	99342	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997		0.034	0.029			1.52			52	10					30			12					
SVY	99342	XXX	Home or residence visit for the evaluation and management of a		53	0.050	0.041	0.99	1.64	1.95	2.60	4.50	48	8			1	20	32	45	90	8	0	0	0	5	100
Physicians	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which		28	0.053	0.043	0.99	1.80	2.50	2.80	4.50	58.5	11			1	20	39	50	90	9	0	0	0	1	100
Podiatrists	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which		24	0.050	0.043	1.00	1.62	1.73	2.01	2.90	40.5	5			1	20	30	40	55	6	0	0	2	15	50
Nurse Practioners	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which		1	0.052	0.039	3.50	3.50	3.50	3.50	3.50	90	20			50	50	50	50	50	20	0	0	0	0	0
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and		20	0.054	0.043			2.60			60	10					40			10					
2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and		12	0.048	0.040			3.50			88	14					59			15					
CURRENT	99344	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997		0.041	0.034			3.38			100	15					60			25					
SVY	99344	XXX	Home or residence visit for the evaluation and management of a		38	0.041	0.035	0.50	2.80	3.15	3.80	65.00	90.5	15			6	31	60	73	100	16	0	0	1	25	209
Physicians	99344	XXX	Home or residence visit for the evaluation and management of a new patient, which		35	0.040	0.034	0.50	2.79	3.10	3.80	65.00	90	14			6	30	60	70	100	16	0	0	1	25	209
Nurse Practioners	99344	XXX	Home or residence visit for the evaluation and management of a new patient, which		3	0.044	0.035	3.00	3.28	3.55	3.78	4.00	101	21			46	53	60	68	75	20	0	0	0	100	200
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and		20	0.048	0.040			3.50			88	14					59			15					
2nd REF	99291	XXX	Initial observation care, per day, for the evaluation and		10	0.051	0.040			2.60			64.5	10					40			14.5					
CURRENT	99345	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997		0.041	0.034			4.09			120	15					75			30					
SVY	99345	XXX	Home or residence visit for the evaluation and management of a		39	0.039	0.033	0.20	3.80	4.00	4.50	75.00	123	25			8	40	74	90	120	24	0	0	1	18	100
Physicians	99345	XXX	Home or residence visit for the evaluation and management of a new patient, which		36	0.040	0.033	0.20	3.80	4.00	4.50	75.00	121	23			8	40	74	90	120	24	0	0	1	20	100
Nurse Practioners	99345	XXX	Home or residence visit for the evaluation and management of a new patient, which		3	0.047	0.035	3.95	3.98	4.00	4.25	4.50	113	26			55	58	60	75	90	27	0	0	0	8	15

Preliminary Survey Data- as of 3-24-2021 Survey Remains Open

Discussion with research committee pending
Updated: 3/26/20212:44 PM

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
15					RUC			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
53	1st REF	99213	XXX	Office or other outpatient visit for the evaluation and		15	0.054	0.043			1.30			30	5					20			5					
54	2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and		3	0.051	0.041			1.92			47	7					30			10					
55	CURRENT	99347	XXX	Home visit for the evaluation and management of an established patient.	4/1/1997		0.044	0.033			1.00			30	5					15			10					
56	SVY	99347	XXX	Home or residence visit for the evaluation and management of		43	0.054	0.043	0.18	0.88	1.30	1.50	30.00	30	5			1	11	20	26	45	5	0	0	0	1	100
57	Physicians	99347	XXX	Home or residence visit for the evaluation and management of an established		34	0.055	0.044	0.18	0.99	1.33	1.50	30.00	30	5			1	12	20	29	45	5	0	0	0	1	100
58	Podiatrists	99347	XXX	Home or residence visit for the evaluation and management of an established		7	0.042	0.033	0.77	0.83	0.90	1.15	2.00	27	7			4	6	15	18	25	5	0	0	0	0	15
59	Nurse Practioners	99347	XXX	Home or residence visit for the evaluation and management of an established		2	0.069	0.048	1.94	2.21	2.47	2.74	3.00	51	8			12	20	29	37	45	15	0	0	0	0	0
61																												
62	1st REF	99213	XXX	Office or other outpatient visit for the evaluation and		22	0.054	0.043			1.30			30	5					20			5					
63	2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and		11	0.051	0.041			1.92			47	7					30			10					
64	CURRENT	99348	XXX	Home visit for the evaluation and management of an established patient.	4/1/1997		0.045	0.035			1.56			44	9					25			10					
65	SVY	99348	XXX	Home or residence visit for the evaluation and management of		43	0.044	0.036	0.20	1.50	1.75	2.15	35.00	49	10			4	18	30	35	60	9	0	0	2	12	500
66	Physicians	99348	XXX	Home or residence visit for the evaluation and management of an established		36	0.047	0.038	0.20	1.50	1.79	2.13	35.00	47	9			4	19	30	35	60	9	0	0	3	11	500
67	Podiatrists	99348	XXX	Home or residence visit for the evaluation and management of an established		6	0.044	0.037	0.80	1.45	1.50	1.69	2.20	41	9			10	15	27	30	42	6	0	0	0	225	500
68	Nurse Practioners	99348	XXX	Home or residence visit for the evaluation and management of an established		1	0.052	0.039	3.50	3.50	3.50	3.50	3.50	90	10			50	50	50	50	50	30	0	0	0	0	0
70																												
71	1st REF	99214	XXX	Office or other outpatient visit for the evaluation and		17	0.051	0.041			1.92			47	7					30			10					
72	2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and		15	0.050	0.040			2.80			70	10					45			15					
73	CURRENT	99349	XXX	Home visit for the evaluation and management of an established patient.	4/1/1997		0.044	0.036			2.33			65	10					40			15					
74	SVY	99349	XXX	Home or residence visit for the evaluation and management of		41	0.050	0.039	0.20	2.19	2.60	3.00	45.00	66	12			5	30	41	45	75	13	0	0	25	120	1841
75	Physicians	99349	XXX	Home or residence visit for the evaluation and management of an established		38	0.049	0.039	0.20	2.14	2.60	3.00	45.00	66	12			5	30	43	45	75	12	0	0	28	120	1841
77	Nurse Practioners	99349	XXX	Home or residence visit for the evaluation and management of an established		3	0.071	0.051	2.30	2.45	2.60	3.30	4.00	51	7			15	23	30	45	60	14	0	0	0	300	600
79																												
80	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and		18	0.050	0.040			2.80			70	10					45			15					
81	2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and		8	0.048	0.040			3.50			88	14					59			15					
82	CURRENT	99350	XXX	Home visit for the evaluation and management of an established patient.	4/1/1997		0.033	0.030			3.28			110	15					75			20					
83	SVY	99350	XXX	Home or residence visit for the evaluation and management of		41	0.050	0.040	0.20	3.00	3.50	4.00	65.00	88	15			7	30	55	66	120	18	0	0	5	25	737
84	Physicians	99350	XXX	Home or residence visit for the evaluation and management of an established		38	0.047	0.038	0.20	3.00	3.50	4.00	65.00	92.5	16			7	33	58	66	120	19	0	0	5	25	737
86	Nurse Practioners	99350	XXX	Home or residence visit for the evaluation and management of an established		3	0.054	0.042	2.60	2.85	3.10	3.80	4.50	74	11			28	37	45	60	75	18	0	0	0	50	100
88																												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Prolonged Services – Clinical Staff Services (PE Only) – Tab 15

In May 2014, the CPT Editorial Panel established two new add-on codes to describe prolonged office observation in conjunction with an evaluation and management (E/M) service, specifically to address additional clinical staff resources in the office or outpatient setting. CPT code 99415 was created to describe the first hour of prolonged clinical staff services provided in addition to an office E/M visit, while CPT code 99416 was created to describe each additional 30 minutes beyond that first hour of prolonged clinical staff service time that was provided in addition to the office E/M. CPT codes 99415 and 99416 are now under consideration by the RUC and Practice Expense (PE) Subcommittee due to the recent changes by the Panel to the prolonged services family code set.

As part of its deliberations, the PE Subcommittee first reviewed and concurred that there is compelling evidence to support an increase in the clinical staff time based on flawed methodology. When the RUC initially valued these add-on codes in September 2014, they assumed a one clinical staff to four patient ratio for these services. Meaning that the clinical staff time was divided among four patients due to anticipated multi-tasking. For 99415, 60 minutes was divided by four patients, hence 15 minutes each. Similarly, the clinical staff time that was included in the original recommendation for 99416 was reached by dividing four patients by 30 minutes for roughly 8 minutes of time. However, since the RUC's original valuation in 2014, changes to CPT language have specifically clarified that the time reported for these codes are for a single patient. This is contradictory to the 1:4 multi-tasking ratio used by the RUC to value these codes and as such, the specialties presented compelling evidence based on flawed methodology which passed unanimously.

The PE Subcommittee thoroughly reviewed the practice expense recommendations for these two codes and approved the inputs with no modifications. The PE Subcommittee noted that the 30 minutes of clinical staff time for 99415 and the 15 minutes for 99416 were appropriately shifted from CA020 *Assist physician or other qualified healthcare professional---directly related to physician work time (other%)* to CA021 *Perform procedure/service---NOT directly related to physician work time.* There are no additional clinical activities recommended and no medical supply inputs. There are only two equipment items, EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *table, exam,* which were deemed appropriate as they are standard inputs for use in the physician office setting.

The PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued. **The RUC recommends the direct practice expense inputs as submitted by the specialty society for CPT codes 99415 and 99416.**

RUC Referral to CPT

The PE Subcommittee asked for additional clarification about how these time-based codes will be tracked and whether these services are required to be provided face-to-face. There was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long

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descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state "direct patient contact with physician supervision;" while the preparatory paragraph for these codes describes "face-to-face time." Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision Codes 99415, 99416 are used when an ~~prolonged~~ evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time ~~beyond the highest total time of the E/M service, as stated in the ranges of time in the code descriptions~~. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services. *Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.* Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported ~~because the clinical staff time involved is included in the E/M codes. The highest total time in the time ranges of the code descriptions is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 39 minutes, and 99415 is not reported until at least 69 minutes total face-to-face clinical staff time has been performed~~. When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff. Codes 99415, 99416 may be reported for no more than two simultaneous patients and the time reported is the time devoted only to a single patient. ~~The use of the time-based add-on codes requires that the primary E/M service has a time published in the CPT code set.~~ For prolonged services by the physician or other qualified health care professional, see ~~99354, 99355,~~ 99417. Do not report 99415, 99416 in conjunction with ~~99354, 99355,~~ 99417. *Facilities may not report 99415, 99416.*				

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(f)✚99415	K3	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service) (Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215) (Do not report 99415 in conjunction with ~~99354, 99355,~~ 99417)	ZZZ	0.00 PE Only
(f)✚99416	K4	each additional 30 minutes (List separately in addition to code for prolonged service) (Use 99416 in conjunction with 99415) (Do not report 99416 in conjunction with ~~99354, 99355,~~ 99417)	ZZZ	0.00 PE Only

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The Total Duration of Prolonged Services Table illustrates the correct reporting of prolonged services provided by clinical staff with physician supervision in the office setting beyond the initial 30 minutes of clinical staff time:

Total Duration of Prolonged Services	***Code(s)***
less than 30 minutes	*Not reported separately*
30-74 minutes *(30 minutes - 1 hr. 14 min.)*	*99415 X 1*
75-104 minutes *(1 hr. 15 min. - 1 hr. 44 min.)*	*99415 X 1 AND 99416 X 1*
105 or more *(1 hr. 45 min. or more)*	*99415 X 1 AND 99416 X 2* *or more for each additional30 minutes.*

The Time Range by Code Table provides the time ranges specific to the office or other outpatient primary service code that are used to report 99415 and the starting point for the first unit of 99416. The starting point for 99415 is 30 minutes beyond the typical clinical staff time for the office visit.

Codes	**99415 time range (minutes)**	**99416 start point (minutes)**
99202	59-103	104
99203	64-108	109
99204	71-115	116
99205	76-120	121
99211	46-90	91
99212	54-98	99
99213	57-101	102
99214	70-114	115
99215	75-119	120

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NON-FACILITY DIRECT PE INPUTS

CPT CODE(S): 99415, 99416

SPECIALTY SOCIETY(IES): AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS

PRESENTER(S): Audrey Chun, MD, Michael Perskin, MD, Robert DeMarco, MD, Phillip Rogers, MD, Steven Krug, MD, Tanvir Hussain, MD, Korinne Van Keuren, DNP, David Regan, MD, Matthew Sideman, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour	ZZZ
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99415	A 52-year-old female presents with gastroenteritis and persistent vomiting. She presents with signs and symptoms of clinical dehydration.
99416	A 52-year-old female presents with gastroenteritis and persistent vomiting. She presents with signs and symptoms of clinical dehydration.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC advisors from the surveying societies acted as an expert panel and met by video conferencing and email to develop the inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   We used the current codes as reference codes for 99415 and 99416.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Yes. 99415 is typically reported with E/M codes 99213, 99214, 99215, and 99416 in the non-facility setting.99416 is typically reported with 99415.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

99415:

Hematology/Oncology is the dominant provided in the non-facility setting at 21.4% of all claims. The dominant provider is not different for the global period.

99416:

Psychiatry is the dominant provider in the non-facility setting at 36.8% of all claims. The dominant provider is not different for the global period.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

Flawed Methodology

The guidelines preceding these codes in *Current Procedural Terminology* (CPT) state, in part:

Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes.

Thus, per CPT, the clinical staff time required to report 99415 must be a **minimum** of 30 minutes. However, the current clinical staff time assigned to 99415 is only 15 minutes, which implies there was a flaw in the methodology used to assign that clinical staff time.

Similarly, for 99416, the CPT guidelines state:

Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Thus, per CPT, the clinical staff time required to report 99416 must be a **minimum** of 15 minutes. However, the current clinical staff time assigned to 99416 is only 8 minutes, which implies there was a flaw in the methodology used to assign that clinical staff time as well.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

The clinical staff is spending this time following up on the patient's care plan, providing care to the patient, and helping the patient understand their care plan.

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

When the provider enters the room, the clinical staff presents the history to the provider in front of the patient, allowing the provider to clarify details. At this point, the clinical staff switches to a scribe role, documenting the provider's physical exam, assessment, and plan. After the provider moves on to the next patient encounter, the clinical staff reviews the care plan and provides appropriate education with the patient.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?
    N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

otoscope-ophthalmoscope (wall unit) – Office visit equipment formula
table, exam – Office visit equipment formula

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

99415: 99415
99416: 99416

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT CODE 99415**		**CPT CODE 99415**		**CPT CODE 99416**	
3		***RUC Collaboration Website***				Prolonged clinical		Prolonged clinical		Prolonged clinical	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	staff service (the service beyond the highest time in the range of total time of		staff service (the service beyond the highest time in the range of total time of		staff service (the service beyond the highest time in the range of total time of	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD: ZZZ**									
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**15.0**	**0.0**	**30.0**	**0.0**	**8.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**15.0**	**0.0**	**30.0**	**0.0**	**8.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D								
16	CA002		L037D								
17	CA003		L037D								
18	CA004		L037D								
19	CA005		L037D								
20	CA006		L037D								
21	CA007		L037D								
22	CA008		L037D								
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009		L037D								
34	CA010		L037D								
35	CA011		L037D								
36	CA012		L037D								
37	CA013		L037D								
38	CA014		L037D								
39	CA015		L037D								
40	CA016		L037D								
41	CA017		L037D								
48		**Intra-service (of service period)**									
49	CA018		L037D								
50	CA019		L037D								
51	CA020		L037D			15	0			8	0
52	CA021		L037D					30	0		
59		**Post-Service (of service period)**									
60	CA022		L037D								
61	CA023		L037D								
62	CA024		L037D								
63	CA025		L037D								
64	CA026		L037D								
65	CA027		L037D								
66	CA028		L037D								
67	CA029		L037D								
68	CA030		L037D								
69	CA031		L037D								
70	CA032		L037D								
71	CA033		L037D								
72	CA034		L037D								
73	CA035		L037D								
74	CA036		L037D			**n/a**		**n/a**		**n/a**	
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037		L037D								
85	CA038		L037D								
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT CODE 99415**		**CPT CODE 99415**		**CPT CODE 99416**	
3		***RUC Collaboration Website***				Prolonged clinical staff service (the service beyond the highest time in the range of total time of		Prolonged clinical staff service (the service beyond the highest time in the range of total time of		Prolonged clinical staff service (the service beyond the highest time in the range of total time of	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD: ZZZ**									
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**15.0**	**0.0**	**30.0**	**0.0**	**8.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**15.0**	**0.0**	**30.0**	**0.0**	**8.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112	EQ189			Office Visits		60		30.0		30	
113	EF023			Office Visits		60		30.0		30	
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	O	P
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**CPT CODE 99416**	
3		***RUC Collaboration Website***	Prolonged clinical	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS**	staff service (the service beyond the highest time in the range of total time of	
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD: ZZZ**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**15.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**15.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**		
14		**Start: Following visit when decision for surgery/procedure made**		
15	CA001			
16	CA002			
17	CA003			
18	CA004			
19	CA005			
20	CA006			
21	CA007			
22	CA008			
29		**End: When patient enters office/facility for surgery/procedure**		
30		**SERVICE PERIOD**		
31		**Start: When patient enters office/facility for surgery/procedure:**		
32		**Pre-Service (of service period)**		
33	CA009			
34	CA010			
35	CA011			
36	CA012			
37	CA013			
38	CA014			
39	CA015			
40	CA016			
41	CA017			
48		**Intra-service (of service period)**		
49	CA018			
50	CA019			
51	CA020			
52	CA021		15	0
59		**Post-Service (of service period)**		
60	CA022			
61	CA023			
62	CA024			
63	CA025			
64	CA026			
65	CA027			
66	CA028			
67	CA029			
68	CA030			
69	CA031			
70	CA032			
71	CA033			
72	CA034			
73	CA035			
74	CA036		**n/a**	
81		**End: Patient leaves office/facility**		
82		**POST-SERVICE PERIOD**		
83		**Start: Patient leaves office/facility**		
84	CA037			
85	CA038			
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**
87		99211 16 minutes		
88		99212 27 minutes		
89		99213 36 minutes		
90		99214 53 minutes		
91		99215 63 minutes		
92	CA039		**0.0**	**0.0**
99		**End: with last office visit before end of global period**		

	A	B	O	P
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**CPT CODE 99416**	
3		***RUC Collaboration Website***	Prolonged clinical staff service (the service beyond the highest time in the range of total time of	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD: ZZZ**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**15.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**15.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**		
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*		
110	**Equipment Code**	**EQUIPMENT**		
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**
112	EQ189		15.0	
113	EF023		15.0	
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*		

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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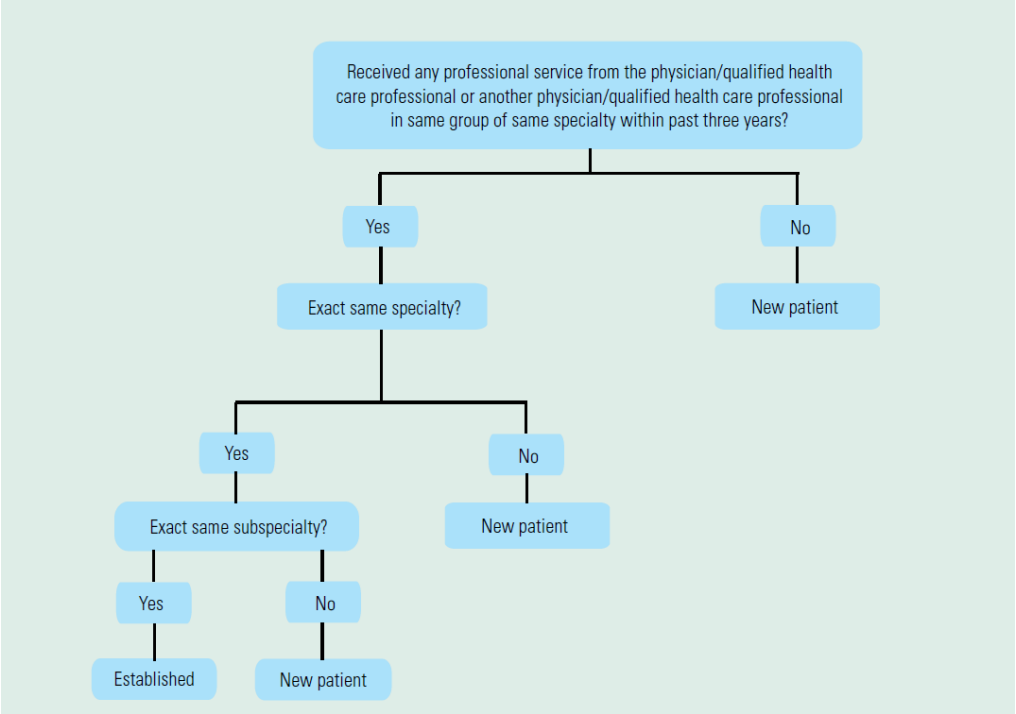
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Cognitive Assessment and Care Plan Services – Tab 16

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel revised code 99483 to replace "50 minutes" from its descriptor with "XX minutes of total time is spent on the date of the encounter", as determined by the RUC survey, to align with the principles included in the E/M office visits.

Due to the increase in office visits for 2021, CMS finalized a proposal to increase CPT code 99483 from 3.44 to 3.80 work RVUs. CMS indicated that 99483 includes an evaluation of a patient's cognitive functioning and requires collecting pertinent history and current cognitive status, all of which require medical decision making of moderate or high complexity. To not create a rank order anomaly with 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU = 3.50), CMS increased 99483 by using the ratio of the increase between the CY 2020 and CY 2021 values for 99205 to commensurate with the increase to CPT code 99205.

99483 ***Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:***

- **Cognition-focused evaluation including a pertinent history and examination,**
- **Medical decision making of moderate or high complexity,**
- **Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity,**
- **Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]),**
- **Medication reconciliation and review for high-risk medications,**
- **Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s),**

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- **Evaluation of safety (eg, home), including motor vehicle operation,**
- **Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks,**
- **Development, updating or revision, or review of an Advance Care Plan,**
- **Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.**

Typically, 60 minutes of total time is spent on the date of the encounter.

The RUC reviewed the survey results from 74 neurologists, geriatricians and internal medicine physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 11 minutes of pre-service time, 60 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU = 3.50, 59 minutes intra-service time and 88 minutes total time) and determined the surveyed code is appropriately valued the same because the vignette for 99205 describes *a new patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function*, which is an extremely intense patient. The RUC did not believe that the typical patient for 99483*, a patient with hypertension, diabetes, arthritis, and coronary artery, disease presents with confusion, weight loss, and failure to maintain her house, where she lives alone*, is more intense. Additionally, the medical decision making (MDM) for CPT code 99205 is at a high level, whereas for CPT code 99483 the MDM is at a moderate/high level of complexity. Lastly, the physician time required for these services is almost identical, 86 minutes (99483) and 88 minutes (99205) total time. Therefore, the RUC determined 99483 should be valued the same as 99205.

The RUC compared 99483 to the second top key reference service 90792 *Psychiatric diagnostic evaluation with medical services* (work RVU = 4.16, 60 minutes intra-service time and 90 minutes total time) and determined that the surveyed code requires less physician time and work and thus is appropriately valued lower.

For additional support, the RUC referenced MPC code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.57 and 70 minutes intra-service and total time). The RUC concluded that CPT code 99483 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.50 for CPT code 99483.**

CPT Descriptor Time
The RUC recommends that the CPT Editorial Panel insert the "60 minutes of total time is spent on the date of the encounter" based on the survey median.

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Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs as submitted by the specialty societies and modified the clinical staff time, moving 6 minutes of CA006 *Confirm availability of prior images/studies* to CA048 *Identify need for imaging, lab or other test result(s) and ensure information has been obtained - three days prior (to be used with E/M only).* The specialty societies consolidated and reduced the clinical staff time for CA021 *Perform procedure/service---NOT directly related to physician work time* to 45 minutes, as outlined in the PE summary of recommendation (SOR) form. The PE Subcommittee adjusted the equipment calculation to the default formula for EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *table, exam*. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cognitive Assessment and Care Plan Services				
▲99483	L1	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation including a pertinent history and examination; • Medical decision making of moderate or high complexity; • Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; • Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); • Medication reconciliation and review for high-risk medications;	XXX	3.50

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		• Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)~~;~~. • Evaluation of safety (eg, home), including motor vehicle operation~~;~~. • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks~~;~~. • Development, updating or revision, or review of an Advance Care Plan~~;~~. • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, ~~50~~ 60 minutes of total time ~~are~~ is spent on the date of the encounter ~~face-to-face with the patient and/or family or caregiver~~. (For services of 75 minutes or longer, use 99417) (Do not report 99483 in conjunction with E/M services [99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99367, 99368, 99497, 99498]; psychiatric diagnostic procedures [90785, 90791, 90792]; brief emotional/behavioral assessment [96127]; psychological or neuropsychological test administration [96146]; health risk assessment administration [96160, 96161]; medication therapy management services [99605, 99606, 99607])		

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CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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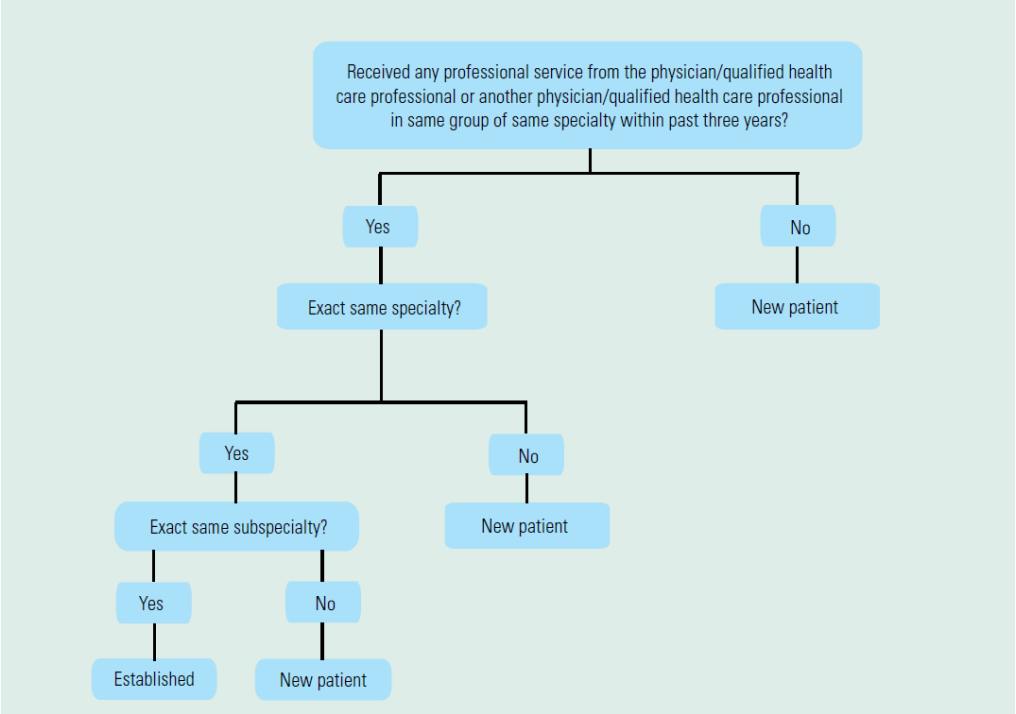
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99483 Tracking Number L1 Original Specialty Recommended RVU: **3.80**
Presented Recommended RVU: **3.50**
Global Period: XXX Current Work RVU: **3.80** RUC Recommended RVU: **3.50**

CPT Descriptor: Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination;
-Medical decision making of moderate or high complexity,
-Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity,
-Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]),
-Medication reconciliation and review for high-risk medications,
-Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s),
-Evaluation of safety (eg, home), including motor vehicle operation,
-Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks,
-Development, updating or revision, or review of an Advance Care Plan,
-Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Typically, 60 minutes of total time is spent on the date of the encounter

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83-year-old female with hypertension, diabetes, arthritis, and coronary artery disease presents with confusion, weight loss, and failure to maintain her house, where she lives alone.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The medical history form is reviewed, and rating scales are completed by the patient and/or family or caregiver. Any medical records obtained from other physicians and other sources (eg, caregiver) are reviewed. Other healthcare professionals are contacted, as necessary.

Description of Intra-Service Work: A complete history, including a focus on the patient's decline, is obtained from the patient, family, and/or caregiver to include identification of potential symptoms that may indicate confounding underlying disease. Vital signs are reviewed. A pertinent physical examination and assessment of affect, cognition, and functional status (basic activities of daily living and instrumental activities of daily living) are performed, including decision-making capacity, mobility, balance, vision, hearing, psychosocial function, and safety (ie, at home and/or driving). The patient is evaluated for neuropsychiatric and behavioral symptoms, including depression, mood instability, psychotic symptoms,

aggression, apathy, and other behavioral disturbance. The stage of dementia is assessed using standardized instruments. A medication reconciliation is completed, and a review for high-risk medications that may affect cognition (separate from rating scales noted in preservice) is performed. The values and preferences of the patient and caregiver for care and goals of care (eg, quality of life, advance care planning) are discussed. The caregivers' relationship to the patient, availability, knowledge, general capability (eg, any physician limitation), and ability and willingness to implement a care plan are evaluated and discussed. Relevant data, options, and risks are considered. A diagnosis is formulated, and a care plan (moderate to high-complexity medical decision making) is developed. A meeting with the clinical care team is held to review findings and develop a care plan. Based on medication reconciliation, a prescription(s) is written, and arrangements for diagnostic testing or referral are made, as necessary. The written care plan is created, and a copy is provided to the patient and/or family or caregiver. Findings and the care plan are reviewed with the patient and/or family or caregiver, to include the etiology and severity of the cognitive impairment, goals of treatment, changes in medication, and recommendations for physical and/or occupational therapy. Safety issues are addressed, caregiving issues are discussed, and recommendations for appropriate community services (eg, rehabilitation services, adult day programs, support groups) are made.

Description of Post-Service Work: Medical record documentation is completed. Other physicians are contacted as necessary to review findings and the care plan. If requested by clinical staff, the patient and/or caregiver are contacted to discuss test results, adverse reactions to medication, and new clinical issues. The care plan is revised, if needed, based on test results.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Kevin Kerber, MD; Katherine, Coerver, MD, PhD; Joshua Liao, MD; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Audrey Chun, MD; Michael Peskin, MD					
Specialty Society(ies):	American Academy of Neurology, American College of Physicians, American Geriatrics Society					
CPT Code:	99483					
Sample Size:	2898	**Resp N:**	74			
Description of Sample:	A random sampling of active US members from each specialty society.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**8.00**	50.00	1000.00
Survey RVW:	1.10	3.50	**4.00**	4.38	60.00
Pre-Service Evaluation Time:			**11.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	46.00	**60.00**	80.00	150.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99483	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**11.00**	**0.00**	**11.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90792	XXX	4.16	**RUC Time**

CPT Descriptor Psychiatric diagnostic evaluation with medical services.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90962	XXX	3.57	**RUC Time**	213,048

CPT Descriptor 1 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49405	000	4.00	**RUC Time**	5,880

CPT Descriptor 2 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous.

Other Reference CPT Code	Global	Work RVU	Time Source
95720	XXX	3.86	**RUC Time**

CPT Descriptor Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG).

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 45 **% of respondents:** 60.8 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 16.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99483	Top Key Reference CPT Code: 99205	2nd Key Reference CPT Code: 90792
Median Pre-Service Time	11.00	14.00	10.00
Median Intra-Service Time	60.00	59.00	60.00
Median Immediate Post-service Time	15.00	15.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**86.00**	**88.00**	**90.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	16%	57%	24%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	40%	31%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	38%	55%
Physical effort required	11%	69%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	49%	44%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	17%	42%	41%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	42%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	33%	59%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT code 99483 was surveyed as the code description was revised by the CPT Editorial Panel to replace "50" from its descriptor with "XX minutes (to be determined via RUC survey) of total time on the date of the encounter is spent on the date of the encounter" to align with the principles included in the office or other outpatient E/M services (99202-99215).

The code was surveyed by the American Academy of Neurology (AAN), the American Geriatrics Society (AGS), and the American College of Physicians (ACP). The survey results were reviewed by an expert panel comprised of the surveying specialties which formulated its recommendations based on that review.

There were 74 respondents, of whom 93% found the vignette to be typical. The survey median RVU was 4.00 with a pre-time of 11 minutes, intra-time of 60 minutes, and post-time of 15 minutes and total time of 86 minutes. The 25th percentile work RVU was 3.5. The first key reference service (chosen by 45 respondents) was 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and work RVU of 14/59/15/88/3.5. The second key reference service was 90792, Psychiatric diagnostic evaluation with medical services, with times and work RVU of 10/60/20/90/4.16.

As a threshold matter, the expert panel agreed that the QHP work for 99483 is still greater than the work of 99205 and agreed with CMS that the increase in work for 99205 (from 3.17 to 3.5) required an increase in work to maintain appropriate rank order. Then the expert panel reviewed the survey data and noted that while the total time went up by one minute, the intra-service time increased by 10 minutes (20%) which supports maintaining the current work RVU of 3.8. The expert panel also noted that while the survey times were very similar to the times for 99205, the current work RVU of 3.8, which is between the 25th percentile and the median, places 99483 in proper rank order with 99205. The panel also noted that 90792 has the same intra-service time as the survey median and four minutes more total time with a work RVU of 4.16 which places it in the correct rank order with 99483 at a work RVU of 3.8.

The expert panel reviewed other RUC reviewed XXX global codes with intra-time between 40 and 75 minutes, total time between 75 and 100 minutes, and work RVU between 3.4 and 4.1. Sixteen codes fit these parameters. Several were codes that are currently undergoing RUC review. The expert panel noted that the other codes supported maintaining the current work RVU. Specifically, 99496, Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge, was RUC reviewed in 2018, and has times and work RVU of 0/75/0/75/3.79 and 95720, Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG), which was RUC reviewed in 2018, has times and work RVU of 10/55/10/75/3.86.

Therefore, the expert panel recommends the survey times: pre-service time of 11 minutes, intra-service time of 60 minutes, and post-service time of 15 minutes and to maintain the current work RVU of 3.8.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99483

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 136935
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 3 times the annual Medicare utilization; based on 2019 utilization data.

Specialty Neurolgoy Frequency 41081 Percentage 30.00 %

Specialty Internal Medicine Frequency 28757 Percentage 21.00 %

Specialty Nurse Practitioner Frequency 23279 Percentage 17.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 45,645
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare utilization from the RUC database.

Specialty Neurology Frequency 13694 Percentage 30.00 %

Specialty Internal Medicine Frequency 9586 Percentage 21.00 %

Specialty Nurse Practitioner Frequency 7760 Percentage 17.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99483

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Cognitive Assessment and Care Plan Services

TAB: 16

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99205	XXX	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES	2019-04	45	0.048	0.040			3.50			88	14					59			15					
2nd REF	90792	XXX	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	2012-04	12	0.058	0.046			4.16			90	10					60			20					
CURRENT	99483	XXX	Assmt & care pln pt cog imp	2016-04		0.060	0.045			3.80			85	15					50			20					
SVY-all	99483	XXX	Assmt & care pln pt cog imp		74	0.057	0.047	1.10	3.50	4.00	4.38	60.00	86	11			5	46	60	80	150	15	0	0	8	50	1000
AAN	99483	XXX	Assmt & care pln pt cog imp		38	0.053	0.044	1.00	3.64	4.00	4.48	7.50	90	10			5	53	65	80	120	15					
AGS	99483	XXX	Assmt & care pln pt cog imp		29	0.055	0.044	1.10	3.50	4.00	4.50	60.00	90	15			10	60	60	90	150	15					
ACP	99483	XXX	Assmt & care pln pt cog imp		7	0.059	0.047	3.00	3.28	3.50	3.95	4.13	75	10			35	43	50	58	70	15					
REC	99483	XXX	Assmt & care pln pt cog imp			0.049	0.041			3.50			86	11					60			15					

SS Rec Summary

SAMPLE COMPLETED WORKSHEET

ISSUE: **[TAB NAME]**

TAB: **84**

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	11111	000	xyz	30	0.029	0.032			4.25			131	5	5	5			30			5				1	1.0			1									
2nd REF	22222	000	def	15	0.055	0.038			5.15			137	10	5	5			35			5					1.0			1	1							
CURRENT	55555	000	abc		0.053	0.038			5.00			133	17					27			8				1	1.0			1								
SVY	55555	000	abc	78	0.045	0.034	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0			1					1	25	50	75	100
REC	55555	000	abc		0.020	0.030	4.25					142	17	1	3			30			10				1	1.0			1								

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99483**

SPECIALTY SOCIETY(IES): AAN, ACP, AGS

PRESENTER(S): Kevin Kerber, MD; Katherine, Coerver, MD, PhD; Joshua Liao, MD; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Audrey Chun, MD; Michael Peskin, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April, 2021
Revised 4-21-21

CPT Code	Long Descriptor	Global Period
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation including a pertinent history and examination, • Medical decision making of moderate or high complexity, • Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, • Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), • Medication reconciliation and review for high-risk medications, • Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), • Evaluation of safety (eg, home), including motor vehicle operation, • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, • Development, updating or revision, or review of an Advance Care Plan, • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99483	The medical history form is reviewed, and rating scales are completed by the patient and/or family or caregiver. Any medical records obtained from other physicians and other sources (eg, caregiver) are reviewed. Other healthcare professionals are contacted, as necessary

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The practice expense survey tool was approved by the AMA Research Subcommittee. 58 respondents completed Survey Part 2 "Direct practice expense detail" of the 98943 RUC survey.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Advisors and subject matter experts from AAN, ACP and AGS met by phone and via email to review the survey data and existing PE inputs to develop final recommendations presented in the PE spreadsheet. The expert panel agreed that the service has not significantly changed since last surveyed in 2018 and as such agreed it is appropriate to maintain the existing PE inputs.
3 clinical activities that were part of the PE Survey have been added:

- CA049 (identify need for imaging, lab or other test result(s) and ensure information has been obtained – day of
- CA050 (review and document history, systems, and medications
- CA052 (coordinate home or outpatient care)

70% of PE survey respondents listed 0 minutes of clinical staff time as typical for the intra-service (of the service period.) The expert panel did not agree with the survey median time of 0 as there are numerous activities performed by clinical staff as explained in detail in Question #10. As such, the expert panel agreed some PE survey respondents may have interpreted the question asking about "*other clinical activity on the calendar day of the cognitive assessment and care plan services visit"* to mean duties outside of 99483, and 0 minutes is not typical.

In response to questions from the pre-facilitation PE Reviewers, the specialty societies further clarified with survey participants if clinical staff are present with the physician or QHP when performing their duties and the feedback was no. The expert panel asserts CA021 is the appropriate clinical staff activity for the intra service period and are recommending 45 minutes (as outlined in question #10).

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

99205 was selected as the reference code for practice expense as it was the key reference service chosen by respondents on the RUC survey.

3. Is this code(s) typically reported with an E/M service?
Is this code(s) typically reported with the E/M service in the nonfacility?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

No

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Neurology – 32%.
Neurology is dominant provide for global as well.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

CA006-confirm availability of prior images / studies.
Standard time is 2 minutes for use in imaging services. The current RUC approved input is 6 minutes and includes gathering medical records obtained from other sources (including history, x-rays and labs if applicable) and referral (where applicable) and prepare for physician review prior to visit. It is typical that a patient being seen for this service will have previous CT and/or MRI scan(s) given the extent of their cognitive impairment.
Also gathering any pre-existing advance care directives and surrogate decision maker forms.

During the RUC PE Subcommittee meeting there was a suggestion to move the 6 minutes to CA048 (Identify need for imaging, lab or other test result(s) and ensure information has been obtained - three days prior (to be used with E/M only)) as CA006 is for imaging services only. The specialty societies agreed CA048 more accurately describes the activities.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A – code was established in 2018. The current RUC approved input for CA010 for 99483 is 3 minutes. Vitals obtained when performing the service include weight, blood pressure, heart rate and respiratory rate.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

- Conduct initial phone call for preliminary assessment of cognitive function to determine if cognitive assessment is appropriate, identify caregivers, who should be present at the visit to provide additional information and with whom the care plan should be shared, and explain what the assessment entails, schedule the visit (and convince patient to come, if necessary).
- Gather medical records obtained from other sources (including history, x-rays and labs if applicable) and referral (where applicable) and prepare for physician review prior to visit.
- Gather any pre-existing advance care directives, surrogate decision maker forms.

   b. Service period (includes pre, intra and post):

Pre-Service Clinical Labor Activities (of Service Period):

- Greet patient (and caregiver, if applicable) and direct to exam room.
- Administer and collate forms for assessing mood, cognitive status, nutrition, functional status for the provider to use.
- Obtain vital signs.

Intra-Service Clinical Labor Activities (of Service Period):

- Gather additional history from caregiver when patient is being examined in a different room including assessing nutritional status, additional caregiver history, ability to participate in activities of daily living, ability to participate in social activities (e.g. adult day memory care center.)
- Administer initial dementia staging screen with standardized instrument prior to physician review.
- Initial medication reconciliation and preparation for physician review
- Administer screen for behavioral symptoms including depression (e.g., PHQ9) for physician review.
- Conduct initial safety screen (e.g., home) including motor vehicle operation.
- Meet with physician and clinical care team to develop written care plan. Compile written care plan inputs from provider include advance care documents. (conveyed in results / outcomes of activities above)
- Meet with family to share and discuss care plan and to educate patient and caregiver on care plan including use of community resources.

Post-Service Clinical Labor Activities (of Service Period):

- Clean room and any utilized equipment

c. Post-service period:

- Follow up phone calls between visits with patient, family, community resources, pharmacy.
- Coordinate future care including home or outpatient care.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Intra-Service Clinical Labor Activities (of Service Period):

- Gather additional history from caregiver when patient is being examined in a different room including assessing nutritional status, additional caregiver history, ability to participate in activities of daily living, ability to participate in social activities (e.g., adult day memory care center.) (10 min)
- Administer initial dementia staging screen with standardized instrument prior to physician review (5 min)
- Initial medication reconciliation and preparation for physician review (10 min)
- Administer screen for behavioral symptoms including depression (e.g., PHQ9) for physician review (10 min)
- Conduct initial safety screen (e.g., home) including motor vehicle operation (5 mins)

- Meet with physician and clinical care team to develop written care plan. Compile written care plan inputs from provider include advance care documents. (conveyed in results / outcomes of activities above)
- Meet with family to share and discuss care plan and to educate patient and caregiver on care plan including use of community resources. (5 min)
- Coordinate future care including home or outpatient care.
- **Total 45 minutes**

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Are you recommending a PE supply pack for this recommendation? **Yes** or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – SA047

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

SA047
(*% indicates percentage of survey responses that found supply typical*)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Cover thermometer probe (1 item) – 71% Drape, non-sterile, 40in x 60 in (1 item) – 21% Gloves, non-sterile (2 pair) – 78% Gown, patient (1 item) – 28% Paper, exam table (7 foot) - 86% Patient education booklet (1 item) – 69% Pillowcase (1 item) - 64% Specula tips, otoscope (1 item) – 53% Swab-pad, alcohol (2 item) – 45% Tongue depressor (1 item) – 48%

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ189 otoscope-ophthalmoscope (wall unit): "office visits" equipment formula EF023 table, exam: "office visits" equipment formula EF048 portable stand-on scale: "other" equipment formula

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**99205**		**99483**		**99483**	
3		***SURVEY DATA: Total Time Medians (SAME MODEL AS E-M PE SURVEY)***				Office or other				**62**	
4		***RUC Collaboration Website***				outpatient visit for		Assessment of and		Assessment of and	
5	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date: 4-15-21** **Tab: 16** **Specialty: AAN, ACP, AGS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per**	the evaluation and management of a new patient, which requires a medically		care planning for a patient with cognitive impairment, requiring an independent		care planning for a patient with cognitive impairment, requiring an independent	
6		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
7		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**	
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	L037D			**56.0**	**0.0**	**14.0**	**0.0**	**30.0**	**0.0**
10		**TOTAL CLINICAL STAFF TIME**	L051A				**0.0**	**78.0**	**0.0**	**62.0**	**0.0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**10.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L051A				**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**46.0**	**0.0**	**8.0**	**0.0**	**24.0**	**0.0**
14		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A				**0.0**	**69.0**	**0.0**	**53.0**	**0.0**
15		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L051A			**0.0**	**0.0**	**9.0**	**0.0**	**9.0**	**0.0**
16		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
17		**PRE-SERVICE PERIOD**									
18		**Start: Following visit when decision for surgery/procedure made**									
19	CA001		L037D								
20	CA002		L037D								
21	CA003		L037D								
22	CA004		L037D								
23	CA005		L037D								
24	CA006		L037D					6		0	
25	CA007		L037D								
26	CA008		L037D								
27	CA048		L037D			10				6	
28			L037D								
29			L037D								
30		*Other activity: please include short clinical description here and type*	L037D								
33		**End: When patient enters office/facility for surgery/procedure**									
34		**SERVICE PERIOD**									
35		**Start: When patient enters office/facility for surgery/procedure:**									
36		**Pre-Service (of service period)**									
37	CA009		L037D			3		3		3	
38	CA010		L037D			5		3		3	
39	CA011		L051A					5		5	
40	CA012		L037D								
41	CA013		L037D			2		2		2	
42	CA014		L037D								
43	CA015		L037D								
44	CA016		L037D			2					
45	CA017		L037D								
46	CA049		L037D			5				3	
47	CA050		L037D			14				5	
48			L037D								
49		*Other activity: please include short clinical description here and type*	L037D								
52		**Intra-service (of service period)**									
53	CA018		L051A					30			
54	CA019		L037D								
55	CA020		L037D			2					
56	CA021		L051A					31		45	
59			L037D								
60		*Other activity: please include short clinical description here and type*	L037D								
63		**Post-Service (of service period)**									
64	CA022		L037D								
65	CA023		L037D								
66	CA024		L037D					3		3	
67	CA024		L037D			3					
68	CA025		L037D								
69	CA026		L037D								
70	CA027		L037D								
71	CA028		L037D								
72	CA029		L037D								
73	CA030		L037D								
74	CA031		L037D								
75	CA032		L037D								
76	CA033		L037D								
77	CA034		L037D								
78	CA035		L037D								
79	CA036		L037D			**n/a**		**n/a**		**n/a**	
80	CA051		L037D			**5**					
81	CA052		L037D			5				5	
82			L037D								
83		*Other activity: CONDUCT ASSESSMENT TESTS column A*	L037D								
86		**End: Patient leaves office/facility**									
87		**POST-SERVICE PERIOD**									
88		**Start: Patient leaves office/facility**									
89	CA037		L051A					9		9	
90	CA037		L037D			11					
91	CA038		L037D								
92		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**99205**		**99483**		**99483**	
3		***SURVEY DATA: Total Time Medians (SAME MODEL AS E-M PE SURVEY)***				Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically				**62**	
4		***RUC Collaboration Website***						Assessment of and care planning for a patient with cognitive impairment, requiring an independent		Assessment of and care planning for a patient with cognitive impairment, requiring an independent	
5	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date: 4-15-21** **Tab: 16** **Specialty: AAN, ACP, AGS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per**						
6		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
7		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**	
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	L037D			**56.0**	**0.0**	**14.0**	**0.0**	**30.0**	**0.0**
10		**TOTAL CLINICAL STAFF TIME**	L051A				**0.0**	**78.0**	**0.0**	**62.0**	**0.0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**10.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L051A				**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**46.0**	**0.0**	**8.0**	**0.0**	**24.0**	**0.0**
14		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A				**0.0**	**69.0**	**0.0**	**53.0**	**0.0**
15		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L051A			**0.0**	**0.0**	**9.0**	**0.0**	**9.0**	**0.0**
106	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
107		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
108	SA047					1		1		1	
109	SK005							1		1	
110	SK062							1		1	
111	SM022	sanitizing cloth-wipe (surface, instruments, equipment)				1				1	
112											
113											
116	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
117		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
118	EQ189			Default		46		77		61	
119	EF023			Default		46		77		61	
120	EF048					2				2	
121											

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/New Services

April 2021

Insertion of Spinal Stability Distractive Device – Tab 17

In July 2020, the Relativity Assessment Workgroup reviewed an action plan for 22867 and 22868 and recommended to remove them from new technology list because there was no demonstrated technology diffusion that impacts work or practice expense. The primary performers of these services did not comment on 22869/22870, as those services are typically performed by other providers. The Workgroup requested an action plan from the primary performers of code 22869 and 22870 (interventional pain management, pain management, anesthesiology and physical medicine and rehabilitation) for review. In December 2020, the Relativity Assessment Workgroup noted that these services are now performed predominantly by a specialty(s) other than the specialty(s) that initially surveyed making the review for new technology difficult to assess. The RUC recommended that CPT codes 22869 and 22870 be surveyed for the April 2021 RUC meeting.

22869 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level***
The RUC reviewed the survey results from 75 physicians and determined that a value between the survey 25th percentile of 6.75 and survey median of 8.00 would most accurately reflect the typical physician work necessary to perform this service. Therefore, the RUC recommends maintaining the current work value for this service of 7.03. The RUC recommends 33 minutes of pre-service evaluation, 12 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 17 minutes of immediate post-service time, a ½ 99238 discharge visit, 1-99213 and 1-99212 post-operative office visits. The specialties noted that the current work for the procedure, as well as the typical patient, has not changed since the previous survey in 2016, only the dominant specialty has changed from surgeon to anesthesiologist and pain physician.

To justify a value of 7.03, the RUC compared 22869 to CPT code 22511 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral* (work RVU= 7.33, intra-service time of 45 minutes, total time of 150 minutes) and noted that both services have identical intra-service times, though the survey code involves more total time. The RUC also compared the survey code to 2nd key reference code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, intra-service time of 45 minutes, total time of 199 minutes) and noted that both services are typically outpatient, involve an identical amount of intra-service time and a similar overall amount of physician work. The RUC concluded that the value of CPT code 22869 should be maintained at 7.03 work RVUs, between the 25th percentile and median of the survey. **The RUC recommends a work RVU of 7.03 for CPT code 22869.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

22870 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 75 physicians and concurred that maintaining the current work value of 2.34 appropriately accounts for the work required to perform this service and is substantially below the survey 25th percentile. The RUC noted that the survey 25th percentile work value of 3.63 supports this recommendation. The RUC recommends 45 minutes of intra-service time for this add-on code.

The RUC compared the survey code to CPT code 15772 *Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service and total time of 45 minutes) and noted that both add-on services involve the same amount of time to perform. The RUC also compared the survey code to CPT code 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU= 2.38, intra-service and total time of 45 minutes), which also requires the same amount of physician time to further support a value of 2.34 for the survey code. The RUC concluded that the current value of CPT code 22870, which falls below the 25th percentile of the survey, should be maintained. **The RUC recommends a work RVU of 2.34 for CPT code 22870.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

RUC Database Flag
The RUC noted that CPT code 22870 should be flagged as "Do not use to validate for physician work."

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	090	7.03 (No change)
22870	second level (List separately in addition to code for primary procedure)	ZZZ	2.34 (No change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

22869, 22870
CPT® Codes

Boston Scientific Corporation
Vendor/Company Name

By: Maria B Stewart

Maria B. Stewart
Printed Signature

Vice President, Global Health Economics & Market Access
Title

March 12, 2021
Date

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22869 Tracking Number Original Specialty Recommended RVU: **7.03**
Presented Recommended RVU: **7.03**
Global Period: 090 Current Work RVU: **7.03** RUC Recommended RVU: **7.03**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A skeletally mature adult with progressive low-back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms in flexion. Imaging confirms mild to moderate spinal stenosis at the L4-L5 level, with approximately 50% reduction in spinal canal area. The implantation of a posterior interspinous process distraction device at one level without an open decompression or a fusion is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 32% , In the ASC 67%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 92% , Overnight stay-less than 24 hours 8% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Perform a targeted H&P. Write orders for preoperative medications and performance standards. Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with the patient and family. Sign and mark the operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite Review imaging, and select and display appropriate pictures. Review the length and type of anesthesia with the anesthesiologist. Monitor initial patient positioning for induction of anesthesia. Following induction of anesthesia, assist with repositioning of patient prone with the lumbar spine in flexion. Verify and/or assist with padding of patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate intraoperative imaging. Supervise prepping/draping of the patient. Scrub and gown. Perform a time out to confirm patient and procedure with the OR staff.

Description of Intra-Service Work: Intraoperative imaging is used to identify the correct level and plan the surgical incision. A posterior lumbar incision is made through the skin, subcutaneous tissue, and lumbosacral fascia. A dilator is inserted through the incision and advanced between the spinous processes and into the interspinous process space under fluoroscopic guidance to confirm levels, position and depth. Additional larger dilators are inserted until the space is distracted to the correct degree. A gauge is used to determine the distance between the two spinous processes, and determine the appropriate implant size. The implant is selected and size verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work: Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in

waiting area. Write brief operative note or complete final operative note in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.

Later same day and on each day patient is in the facility, monitor and document patient progress. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, imaging, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Next day or several days later. Write orders for follow-up, post-discharge labs, imaging, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

In Office: Write orders for medications and follow-up films. Review post-discharge films. Examine patient, performing periodic neurological exams. Monitor wounds and remove sutures. Review use and proper fit of brace with patient. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer questions (oral and written) from patient, family and insurance staff. Discuss patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	David Reece, DO, Richard Rosenquist, MD, Michael Lubrano, MD, Damean Freas, MD, Kano Mayer, MD, Karin Swartz, MD					
Specialty Society(ies):	AAPM&R, ASA, ASIPP, NANS, NASS					
CPT Code:	22869					
Sample Size:	1746	**Resp N:**	75			
Description of Sample:	Targeted vendor sample and random society sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	4.00	**10.00**	15.00	75.00	
Survey RVW:	1.20	6.75	**8.00**	10.96	75.00	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**12.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	20.00	39.00	**45.00**	60.00	105.00	
Immediate Post Service-Time:	**17.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	22869	**Recommended Physician Work RVU: 7.03**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**17.00**	**33.00**	**-16.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63655	090	10.92	**Other**

CPT Descriptor Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29880	090	7.39	**RUC Time**

CPT Descriptor Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
15823	090	6.81	**RUC Time**	97,994

CPT Descriptor 1 Blepharoplasty, upper eyelid; with excessive skin weighting down lid

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

Other Reference CPT Code	Global	Work RVU	Time Source
29881	090	7.03	**RUC Time**

CPT Descriptor Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 36.0 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 18.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 22869	Top Key Reference CPT Code: 63655	2nd Key Reference CPT Code: **29880**
Median Pre-Service Time	58.00	63.00	58.00
Median Intra-Service Time	45.00	90.00	45.00
Median Immediate Post-service Time	17.00	20.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	39.0	62.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**178.00**	**254.00**	**199.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	19%	44%	26%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	56%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	22%	52%	26%
Physical effort required	7%	56%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	48%	19%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	36%	36%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	36%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	57%	36%
Physical effort required	0%	58%	42%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	21%	29%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In June 2020, the RUC's Relativity Assessment Workgroup (RAW) flagged four CPT codes (22867, 22868, 22869 and 22870) for review under the New Technology Screen. The four codes were originally surveyed in 2015 for inclusion in the 2016 CPT and the Medicare Physician Fee Schedule (PFS). In 2015, the RUC recommended 7.39 work RVUs for 22869 and 2.34 wRVUs for 22870. Subsequently, in the 2016 Medicare PFS CMS finalized a reduced value of 7.03 work RVUs for 22869 but accepted the RUC recommendation of 2.34 work RVUs for 22870.

The initial RAW Action Plan for the four codes was developed by the specialty societies that surveyed the codes in 2015: the American Academy of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), the American Academy of Orthopaedic Surgeons (AAOS), the North American Spine Society (NASS) and the International Society for the Advancement of Spine Surgery (ISASS). In their action plan the original surveying societies noted that codes 22869 *(Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level*) and 22870 *(Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure))* were performed predominately by interventional pain physicians and anesthesiologists; and therefore recommended these societies review the codes and present an action plan for the next RAW meeting.

For the RAW's December 2020 meeting, anesthesiology and the interventional pain societies (American Society of Anesthesiologists-ASA, American Academy of Physical Medicine and Rehabilitation –(AAPM&R), North American Spine Society (NASS), and the American Society of Interventional Pain Physicians (ASIPP)) presented an action plan recommending no action and maintaining current value. The RUC disagreed and requested the societies resurvey the codes.

The societies, along with the North American Neuromodulation Society (NANS) proceeded with a survey of the two codes. In preparing the survey, the societies submitted a request to the RUC Research Subcommittee (RSC) to use a list from the vendor of physicians trained to perform the service as well as random samples of members from the surveying societies. The RSC approved the request at their February 2021 meeting. The surveying societies noted that their members do not report other 90-day global codes so would have a difficult time using one as an accurate reference code. The societies requested approval to include 10-day global codes in the RSL. The RSC did not approve this request and advised the specialties to use 90-day global codes that their members may be familiar with from training. The societies followed this guidance and the RSL that was used did not include any 010 global codes per the RSC guidance.

The societies conducted their survey in March 2021, using the approved vendor contact list and blending this with random samples from respective societies.

There were a total of 75 non-conflicted responses, of which 56 were from the vendor list and 19 were from society lists. The median experience in the previous 12 months for all respondents was 10 for 22869 and 5 for 22870. For the trained physicians who responded the median experience in the previous 12 months was 10 for 22869 and 2 for 22870.

Recommendation – 22869

Work RVU

The Survey median work RVU was 8.00 and the survey 25th % was 6.75.

We recommend maintaining the current work RVU of 7.03 which sits in-between the survey 25th% and the median.

Pre-Service Time

The societies recommend package 3 for pre-service package time which was also the recommended package in the original survey.

We recommend 33 minutes of pre-service evaluation time with no change from package 3.

We recommend 12 minutes of pre-service positioning time, which is the survey median. As this is a spine procedure/prone position 9 minutes are recommended in addition to the 3 minutes package time. Current positioning time is 15 minutes.

We recommend 10 minutes of pre-service Scrub, Dress and Wait (SDW) time, which is 5 minutes less than the SDW time for package 3 and 5 minutes less than the current SDW time. 10 minutes was the median time from the survey.

Intra-Service Time

The societies recommend 45 minutes intra-service time, which is the survey median. This is nearly identical to the current/previous intra-service time of 43 minutes.

Immediate Post-Service Time

The societies recommend Immediate Post-Service package 9a but recommend subtracting 12 minutes to equal the 17 minutes median survey time. This is less than the current post-service time of 30 minutes, but the previous survey median immediate post-service time was 20 minutes. An additional 10 minutes of immediate post-service time was added by recommendation to reflect the previous survey respondents indicating the primary site-of-service as outpatient with a follow-up E/M visit on the same day as the procedure. The RUC database billed together data indicates that no other services (other than the add-on code 22870) are billed on the same day.

Post-Service Visits and Site-of-Service

Survey respondents indicated the primary site-of-service as ASC, with 67% indicating they typically perform the procedure in this facility setting. 32% indicated they typically perform the procedure in a hospital setting and 1% indicated office as their typical site of service.

Societies recommend a half-day discharge for the facility ASC setting with no additional time for a visit on the same day of service.

Survey respondents indicated a median of 3 level 3 post-operative office visits. The societies, however, recommend maintaining the current post-operative office visits at 1-99213 and 1-99212 to maintain consistency with the current values and times.

Key Reference Code Comparison

KRS1: The most typical KRS was CPT code 63655*(Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*) with respondents who chose 63655 as a reference indicated the intensity/complexity of 63655 as less or much less than 22867.

KRS2: The second most common KRS was CPT code 29880 (*Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed*). 29880 has the same intra-service time as 22867 at 45 minutes and a very similar work RVU at 7.39. 29880 was also the code the RUC used to crosswalk 22867 to in the 2015 RUC review and is equal to the 2015 RUC recommended value. Survey respondents indicated its intensity and complexity to be less than the survey code of 22867.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.03	0.076	178	63	45	17 immed 0.5-99238 1-99213 1-99212
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.	7.39	0.065	199	58	45	15-immed 0.5-99238 2-99213 1-99212
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	10.92	0.069	254	63	90	20-immed 0.5-99238 2-99213 1-99212

MPC Codes

22869's current value and our recommended work RVU of 7.03 is well bracketed by MPC codes with the same intra-service time and similar intensities and total times. The two MPC codes are CPT 15823 with a work RVU of 6.82 and CPT 26115 with a work RVU of 7.07.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	6.82	0.072	161	17	45	10-immed 0.5-99238 1-99213 3-99212
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.03	0.076	178	63	45	17 immed 0.5-99238 1-99213 1-99212
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	7.97	0.089	185	35	45	15-immed 0.5-99238 1-99213 3-99212

Other Code Comparison

CPT code 29881 (*Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed*) represents the CMS crosswalk code for 22867 and the societies believe is currently a good crosswalk to support the current 7.03 work RVU. The two codes have identical intra-service time, similar pre-service times, and 22867 is appropriately slightly higher in intensity.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	7.03	0.064	194	58	40	15-immed 0.5-99238 2-99213 1-99212
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.03	0.076	178	63	45	17 immed 0.5-99238 1-99213 1-99212

Summary

The societies recommend for CPT code 22869 (*Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level*) the following:

Work RVU: 7.03 (current value)

Pre-Service Package: 3

Evaluation: 33 minutes

Positioning: 12 minutes (spine/prone)

SDW: 10 minutes

Intra-Service Time: 45 minutes

Immediate Post Service Package: 9A -13 minutes to equal 17 minutes (survey median SDW time)

Hospital Discharge: 0.5 - 99238

Office Visits: 1-99213, 1-99212

Total Time: 178 minutes

The societies believe the survey data supports the current value and shows that the work performed by anesthesiology and interventional pain physicians to be identical to the previous work survey performed by spine surgeons in 2015 and

recommend current value with time inputs either remaining the same as current or adjusted to median survey results when appropriate.

The current work for the procedure, as well as the typical patient, has not changed since the previous survey, only the dominant specialty has changed from surgeon to anesthesiologist and pain physician. It is also not surprising for there to be shifts in the type of physician performing a procedure that is relatively new such as 22869 and 22870 while the patient and work remains the same. Furthermore, there would be no reason to expect the pre-service or post-service physician work to change substantially based on the type of physician performing the service. The survey data, showing the same or slightly more time in the pre, intra, and post-service periods, confirms this relative consistency even as the type of physician performing the procedure has changed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 22869

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Pain Management How often? Rarely

Specialty Pain Management How often? Rarely

Specialty Anesthesiology How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 20385
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Interventional Pain Management Frequency 6279 Percentage 30.80 %

Specialty Pain Management Frequency 5688 Percentage 27.90 %

Specialty Anesthesiology Frequency 4933 Percentage 24.19 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,795
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Interventional Pain Management Frequency 2093 Percentage 30.80 %

Specialty Pain Management Frequency 1896 Percentage 27.90 %

Specialty Anesthesiology Frequency 1644 Percentage 24.19 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22869

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22870 Tracking Number Original Specialty Recommended RVU: **2.34**
Presented Recommended RVU: **2.34**
Global Period: ZZZ Current Work RVU: **2.34** RUC Recommended RVU: **2.34**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A skeletally mature adult with progressive low-back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms while in flexion. Imaging confirms mild to moderate spinal stenosis at the L3-L4 level with 25% reduction in the canal area and at L4-L5 with a 50% reduction. The implantation of a posterior interspinous process distraction device without an open decompression or a fusion at both levels is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After insertion of the initial lumbar interlaminar/interspinous process stabilization/distraction device with decompression (reported separately), the incision is extended to expose the adjacent level. A dilator is inserted through the incision and advanced between the spinous processes and into the interspinous process space under fluoroscopic guidance to confirm position and depth. Additional larger dilators are inserted until the space is distracted to the correct degree. A gauge is used to determine the distance between the two spinous processes, and determine the appropriate implant size. The implant is selected and size verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	David Reece, DO, Richard Rosenquist, MD, Michael Lubrano, MD, Damean Freas, MD, Kano Mayer, MD, Karin Swartz, MD					
Specialty Society(ies):	AAPM&R, ASA, ASIPP, NANS, NASS					
CPT Code:	22870					
Sample Size:	1746	**Resp N:**	75			
Description of Sample:	Targeted vendor sample and random society sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**5.00**	10.00	70.00	
Survey RVW:	1.30	3.63	**5.00**	7.03	50.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	30.00	**45.00**	60.00	220.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22870	**Recommended Physician Work RVU: 2.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22515	ZZZ	4.00	**RUC Time**

CPT Descriptor Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63048	ZZZ	3.47	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36476	ZZZ	2.65	**RUC Time**	7,170

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
15772	ZZZ	2.50	**RUC Time**

CPT Descriptor Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 35 **% of respondents:** 46.6 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 17.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 22870	**Top Key Reference CPT Code:** 22515	**2nd Key Reference CPT Code:** **63048**
Median Pre-Service Time	0.00	1.00	0.00
Median Intra-Service Time	45.00	30.00	45.00
Median Immediate Post-service Time	0.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**32.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	35%	37%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	26%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	59%	32%
Physical effort required	6%	54%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	49%	34%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	54%	23%	15%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	46%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	31%	38%	32%
Physical effort required	8%	25%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	39%	46%	15%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In June 2020, the RUC's Relativity Assessment Workgroup (RAW) flagged four CPT codes (22867, 22868, 22869 and 22870) for review under the New Technology Screen. The four codes were originally surveyed in 2015 for inclusion in the 2016 CPT and the Medicare Physician Fee Schedule (PFS). In 2015, the RUC recommended 7.39 work RVUs for 22869 and 2.34 wRVUs for 22870. Subsequently, in the 2016 Medicare PFS CMS finalized a reduced value of 7.03 work RVUs for 22869 but accepted the RUC recommendation of 2.34 work RVUs for 22870.

The initial RAW Action Plan for the four codes was developed by the specialty societies that surveyed the codes in 2015: the American Academy of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), the American Academy of Orthopaedic Surgeons (AAOS), the North American Spine Society (NASS) and the International Society for the Advancement of Spine Surgery (ISASS). In their action plan the original surveying societies noted that codes 22869 *(Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level*) and 22870 *(Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure))* were performed predominately by interventional pain physicians and anesthesiologists; and therefore recommended these societies review the codes and present an action plan for the next RAW meeting.

For the RAW's December 2020 meeting, anesthesiology and the interventional pain societies (American Society of Anesthesiologists-ASA, American Academy of Physical Medicine and Rehabilitation –(AAPM&R), North American Spine Society (NASS), and the American Society of Interventional Pain Physicians (ASIPP)) presented an action plan recommending no action and maintaining current value. The RUC disagreed and requested the societies resurvey the codes.

The societies, along with the North American Neuromodulation Society (NANS) proceeded with a survey of the two codes. In preparing the survey, the societies submitted a request to the RUC Research Subcommittee (RSC) to use a list from the vendor of physicians trained to perform the service as well as random samples of members from the surveying societies. The RSC approved the request at their February 2021 meeting. The surveying societies noted that their members do not report other 90-day global codes so would have a difficult time using one as an accurate reference code. The societies requested approval to include 10-day global codes in the RSL. The RSC did not approve this request and advised the specialties to use 90-day global codes that their members may be familiar with from training. The societies followed this guidance and the RSL that was used did not include any 010 global codes per the RSC guidance.

The societies conducted their survey in March 2021, using the approved vendor contact list and blending this with random samples from respective societies.

There were a total of 75 non-conflicted responses, of which 56 were from the vendor list and 19 were from society lists. The median experience in the previous 12 months for all respondents was 10 for 22869 and 5 for 22870. For the trained physicians who responded the median experience in the previous 12 months was 10 for 22869 and 2 for 22870.

Recommendation – 22870

Work RVU

The survey median work RVU was 5.00 and the survey 25th% work RVU was 3.63.

We recommend maintaining the current work RVU of 2.34 which is substantially below the 25th% survey work RVU.

Pre-Service Time

N/A, 22870 is a ZZZ code

Intra-Service Time

The societies recommend 45 minutes intra-service time, which is the survey median. This is an increase from the previous survey median and current time of 30 minutes

Immediate Post-Service Time

N/A, 22870 is a ZZZ code

Post-Service Visits and Site-of-Service

N/A, 22870 is a ZZZ code

Key Reference Code Comparison

KRS1: The most typical KRS was CPT code 22515 (*Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)*).

KRS2: The second most common KRS was CPT code 63048 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)).*

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	2.34	0.052	45		45	
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure).	3.48	0.077	45		45	
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	4.00	0.132	32	1	30	1

MPC Codes

There is a dearth of ZZZ codes on the MPC list and only one code with the same intra-service time and under 4.00 which is 63048, one of the survey key reference codes.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance	2.34	0.052	45		45	

	when performed, lumbar; second level (List separately in addition to code for primary procedure)						
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2.65	0.883	30		30	
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure).	3.48	0.077	45		45	

Other Code Comparison

CPT code 15772 (*Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure*)) is one of several ZZZ codes that has the same or lower time but a similar or higher work RVU and support the recommended value of 2.34.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	2.50	.055	45		45	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	2.34	0.052	45		45	

Summary

The societies recommend for CPT code 22870 (*nsertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)*) the following:

Work RVU: 2.34 (current value)

Intra-Service Time: 45 minutes

Total Time: 45 minutes

The societies believe the survey data supports the current value and shows that the work performed by anesthesiology and interventional pain physicians to be identical to the previous work survey performed by spine surgeons in 2015 and recommend current value with time inputs adjusted to median survey intra-service time of 45 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Report with code 22869.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 22870

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Pain Management How often? Rarely

Specialty Pain Management How often? Rarely

Specialty Anesthesiology How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 8652
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Interventional Pain Management Frequency 2890 Percentage 33.40 %

Specialty Pain Management Frequency 2509 Percentage 28.99 %

Specialty Anesthesiology Frequency 2007 Percentage 23.19 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,884
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Interventional Pain Management Frequency 963 Percentage 33.39 %

Specialty Pain Management Frequency 836 Percentage 28.98 %

Specialty Anesthesiology Frequency 669 Percentage 23.19 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22870

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Insertion of Spinal Stability Distractive Device

TAB: 17

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	63655	90	Laminectomy for implantation of neurostimulator electrodes, plate/paddle,	2010		0.069	0.043			10.92			254	33	15	15			90			20						0.5				2	1					
2nd REF	29880	90	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral,	2011		0.065	0.037			7.39			199	33	10	15			45			15						0.5				2	1					
CURRENT	22869	90	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion,	2017		0.071	0.036			7.03			194	33	15	15			43			30						0.5				1	1					
SVY	22869	90	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when		75	0.074	0.040	1.20	6.75	8.00	10.96	75.00	198	45	12	10	20	39	45	60	105	17										3			0	4	10	15	75
Targeted Vendor List	22869	90	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when		56	0.076	0.041	3.00	6.00	8.00	10.23	75.00	194	45	10	10	20	40	45	60	90	15										3			1	5	10	19	75
Random Society Sample	22869	90	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when		19	0.140	0.056	1.20	7.70	10.00	11.50	14.00	180	45	12	15	25	35	45	60	105	17										2			0	0	2	10	36
REC	22869	90	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level		75	0.077	0.040			7.03			175	33	12	10			45			17						0.5				1	1					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	22515	ZZZ	Percutaneous vertebral augmentation, including cavity creation (fracture	2014		0.132	0.125			4.00			32	1					30			1																
2nd REF	63048	ZZZ	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with	2013		0.077	0.077			3.47			45						45																			
CURRENT	22870	ZZZ	Insertion of interlaminar/interspinous process stabilization/distraction device,	2017		0.078	0.078			2.34			30						30																			
SVY	22870	ZZZ	Insertion of interlaminar/interspinous process stabilization/distraction device,		75	0.111	0.111	1.30	3.63	5.00	7.03	50.00	45				1	30	45	60	220														0	2	5	10	70
Targeted Vendor List	22870	ZZZ	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when		56	0.100	0.100	2.50	3.50	4.50	6.63	50.00	45				1	30	45	60	180														0	3	7	11	70
Random Society Sample	22870	ZZZ	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when		19	0.144	0.144	1.30	4.00	5.75	9.00	14.00	40				15	30	40	70	220														0	0	1	5	30
REC	22870	ZZZ	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)			0.052	0.052			2.34			45						45																			

FACILITY DIRECT PE INPUTS **CPT CODE(S):_22869, 22870__**
SPECIALTY SOCIETY(IES):_AAPM&R, ASIPP, ASA, NANS, NASS_
PRESENTER(S):_Damean Freas, MD; Kano Mayer, MD, David Reece, DO; Richard Rosenquist, MD; and Karin Swartz, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 21, 2021

CPT Code	Long Descriptor	Global Period
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	090
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
22869	A skeletally mature adult with progressive low-back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms in flexion. Imaging confirms mild to moderate spinal stenosis at the L4-L5 level, with approximately 50% reduction in spinal canal area. The implantation of a posterior interspinous process distraction device at one level without an open decompression or a fusion is recommended.
22870	A skeletally mature adult with progressive low-back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms while in flexion. Imaging confirms mild to moderate spinal stenosis at the L3-L4 with 25% reduction in the canal area and at L4-L5 with a 50% reduction. The implantation of a posterior interspinous process distraction device at one level without an open decompression or a fusion is recommended.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty societies convened an expert panel of advisors from the presenting specialties via telephone to discuss recommendations for practice expense for codes 22869 and 22870. The panel reviewed existing inputs for these codes and considered any necessary modifications.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The expert panel used the existing inputs for codes 22869 and 22870 as reference for the new recommendations.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

For code 22869

Complete pre-service diagnostic and referral forms	**5 minutes (standard)** Staff reviews all forms with patient and/or caregiver to ensure all relevant history and diagnostic information is included
Coordinate pre-surgery services (including test results)	**20 minutes (standard)** Staff coordinates collection and documentation of test results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Staff coordinate requisite pre-surgery appointments and visits. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	**8 minutes (standard)** Staff interacts with facility to schedule space, supplies, equipment, and review checklists
Provide pre-service education/obtain consent	**20 minutes (standard)** Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions. Staff conduct a pre-clearance assessment and final clearance for surgery
Complete pre-procedure phone calls and prescription	**7 minutes (standard)** Staff reviews preoperative medication changes, reviews patient medical status, confirms preoperative cleansing protocol, and answers final pre-admission questions.

   b. Service period (includes pre, intra and post):

6 minutes (standard)
Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as:

- Responding to patient/family questions about home activity restrictions/WB status, therapy questions
- Telephonic or electronic communication assistance with the office, and other necessary management assistance related to the hospitalization.

- Transitioning discharge information to the office medical record, including correspondence and imaging or lab results pending at discharge

c. Post-service period:

63 minutes – standard clinical staff time for current office visit E/Ms (one 99213, one 99212) Clinical staff will greet the patient, provide gowning, and ensure that all appropriate medical records are available including interval imaging and labs, physical therapy reports, and chart notes from other physicians. Clinical staff will obtain vital signs, prepare the room and necessary supplies, assist with patient positioning for exam, review and document history, systems and medications. Clinical staff will assist the physician during the exam which may include wound and drain (if present) assessment, neurovascular assessment, and ROM assessment. Clinical staff will clean the room and answer any patient/family questions about home care including activity limitations and reinforcement of physical therapy activities. Clinical staff will assist the physician with orders for medication and physical therapy changes. Clinical staff will assist with answering patient, family, caregiver, therapist, other clinician questions and help process changes in care.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes, two supply packs are used.
The supply packs are established packs as defined by CMS.

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**2.1122**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (staple)	**SA052**	**pack**		**4.992**
kit, staple removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031	table, power	Time is equal to office visit total time based on current database time.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 22869**		**CPT Code 22869**		**CPT Code 22870**	
3		***RUC Collaboration Website***				Insertion of interlaminar / interspinous process stabilization/distraction device, without		Insertion of interlaminar / interspinous process stabilization/distraction device, without		Insertion of interlaminar / interspinous process stabilization/distraction device, without	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAPM&R, ASA, ASIPP, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**129.0**	**0.0**	**129.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**63.0**	**0.0**	**63.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D				5		5		
16	CA002		L037D				20		20		
17	CA003		L037D				8		8		
18	CA004		L037D				20		20		
19	CA005		L037D				7		7		
20	CA006		L037D								
21	CA007		L037D								
22	CA008		L037D								
23			L037D								
26		*Other activity: please include short clinical description here and type*	L037D								
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009		L037D								
34	CA010		L037D								
35	CA011		L037D								
36	CA012		L037D								
37	CA013		L037D								
38	CA014		L037D								
39	CA015		L037D								
40	CA016		L037D								
41	CA017		L037D								
42			L037D								
45		*Other activity: please include short clinical description here and type*	L037D								
48		**Intra-service (of service period)**									
49	CA018		L037D								
50	CA019		L037D								
51	CA020		L037D								
52	CA021		L037D								
55			L037D								
56		*Other activity: please include short clinical description here and type*	L037D								
59		**Post-Service (of service period)**									
60	CA022		L037D								
61	CA023		L037D								
62	CA024		L037D								
63	CA025		L037D								
64	CA026		L037D								
65	CA027		L037D								
66	CA028		L037D								
67	CA029		L037D								
68	CA030		L037D								
69	CA031		L037D								
70	CA032		L037D								
71	CA033		L037D								
72	CA034		L037D								
73	CA035		L037D								
74	CA036		L037D			**n/a**	**6**	**n/a**	**6**	**n/a**	
75			L037D								
78		*Other activity: please include short clinical description here and type*	L037D								
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037		L037D								
85	CA038		L037D								
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27				1		1		
89		99213 36 minutes	36				1		1		
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039		L037D			**0.0**	**63.0**	**0.0**	**63.0**	**0.0**	**0.0**
93			L037D								
96		*Other activity: please include short clinical description here and type*	L037D								
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 22869**		**CPT Code 22869**		**CPT Code 22870**	
3		***RUC Collaboration Website***				Insertion of interlaminar / interspinous process stabilization/distraction device, without		Insertion of interlaminar / interspinous process stabilization/distraction device, without		Insertion of interlaminar / interspinous process stabilization/distraction device, without	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAPM&R, ASA, ASIPP, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**129.0**	**0.0**	**129.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**63.0**	**0.0**	**63.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102	SA048						2		2		
103	SA054						1		1		
104											
105											
106											
107											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112	EF031			Office Visits			63		63		
113	EQ168			Office Visits			63				
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	O	P
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**CPT Code 22870**	
3		***RUC Collaboration Website***	Insertion of interlaminar / interspinous process stabilization/distraction device, without	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAPM&R, ASA, ASIPP, NANS, NASS**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**		
14		**Start: Following visit when decision for surgery/procedure made**		
15	CA001			
16	CA002			
17	CA003			
18	CA004			
19	CA005			
20	CA006			
21	CA007			
22	CA008			
23				
26		*Other activity: please include short clinical description here and type*		
29		**End: When patient enters office/facility for surgery/procedure**		
30		**SERVICE PERIOD**		
31		**Start: When patient enters office/facility for surgery/procedure:**		
32		**Pre-Service (of service period)**		
33	CA009			
34	CA010			
35	CA011			
36	CA012			
37	CA013			
38	CA014			
39	CA015			
40	CA016			
41	CA017			
42				
45		*Other activity: please include short clinical description here and type*		
48		**Intra-service (of service period)**		
49	CA018			
50	CA019			
51	CA020			
52	CA021			
55				
56		*Other activity: please include short clinical description here and type*		
59		**Post-Service (of service period)**		
60	CA022			
61	CA023			
62	CA024			
63	CA025			
64	CA026			
65	CA027			
66	CA028			
67	CA029			
68	CA030			
69	CA031			
70	CA032			
71	CA033			
72	CA034			
73	CA035			
74	CA036		**n/a**	
75				
78		*Other activity: please include short clinical description here and type*		
81		**End: Patient leaves office/facility**		
82		**POST-SERVICE PERIOD**		
83		**Start: Patient leaves office/facility**		
84	CA037			
85	CA038			
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**
87		99211 16 minutes		
88		99212 27 minutes		
89		99213 36 minutes		
90		99214 53 minutes		
91		99215 63 minutes		
92	CA039		**0.0**	**0.0**
93				
96		*Other activity: please include short clinical description here and type*		
99		**End: with last office visit before end of global period**		

	A	B	O	P
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**CPT Code 22870**	
3		***RUC Collaboration Website***	Insertion of interlaminar / interspinous process stabilization/distraction device, without	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAPM&R, ASA, ASIPP, NANS, NASS**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**		
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**
102	SA048			
103	SA054			
104				
105				
106				
107				
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*		
110	**Equipment Code**	**EQUIPMENT**		
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**
112	EF031			
113	EQ168			
114				
115				
116				
117				
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly*

April 2021

Knee Arthroplasty – Tab 18

In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management (E/M) services within the global period and 2019e Medicare utilization over 10,000. The Workgroup concluded that CPT code 27446 represents a site of service anomaly since visits are currently included in the valuation of this service that are not typically occurring. The RUC recommended that CPT code 27446 be surveyed for January 2021 with the appropriate code family. At the January 2021 meeting, the specialty societies submitted a request to defer survey until April 2021 due to logistical reasons including timing and a desire to be placed on the Research Subcommittee agenda "to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work." The RUC recommended that CPT code 27446 be surveyed for April 2021 with the appropriate code family.

Pre-Service Work
In October 2019 during review of CPT code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*, the specialties noted that considerable work by the clinical staff, surgeons, and qualified healthcare providers (QHPs) is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. The service has also evolved in that patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

The RUC agreed that the pre-service planning activities are being performed on a routine basis for the typical patient; however, the 090-day global period structure does not allow inclusion of this work. In addition, the current code does not include this additional work in the descriptor. The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP. The RUC indicated that separate planning codes may be developed, or current codes such as the prolonged service codes may be reported for these activities. It was recognized that such codes are intended to capture a single episode of time and that the added work in the preoperative period does not occur in such units of time (e.g., 30 minutes in one session as opposed to over the course of a few days/calls).

The RUC affirmed the October 2019 recommendation for CPT code 27447 and noted that the pre-service time discussion also applies to family code 27446. The RUC recommends that the specialty, and other interested parties, consider developing a CPT coding application to address this preoperative period issue.

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27446 ***Arthroplasty, knee, condyle and plateau; medial OR lateral compartment***
The RUC reviewed the survey results from 126 orthopaedic and hip/knee surgeons and concurred that the survey median (19.60) and 25th percentile (18.60) work RVU overvalued the physician work for this service. Therefore, the RUC determined that a direct work RVU crosswalk to CPT code 67108 *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU= 17.13, 90 minutes intra-service time and 295 minutes total time) appropriately accounts for relative physician work. The crosswalk code was surveyed in 2015 and has identical intra-service time as 27446 and similar total time and intensity. The RUC notes that the crosswalk value of 17.13 work RVUs includes three key considerations: no change in intraoperative time, one day less of hospital E/M work, and an increase in level of postoperative office work.

The RUC recommends the following physician time components: 40 minutes pre-service evaluation, 15 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, and 45 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 and 1-99214 office visits, 310 minutes total time. Pre-service time package 4 is recommended with an increase of 12 minutes to positioning time (total = 15 minutes) to account for assisting with appropriately positioning the patient, padding bony prominences, and applying thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; placing the patient's leg properly on the table and positioning with proper bolstering to aid surgical exposure; placing a tourniquet on the proximal thigh; confirming tourniquet settings and validating function. This is consistent with both the survey median and historical RUC precedent for many similar orthopaedic extremity surgical codes. In addition, the package time for scrub/dress/wait was reduced to 15 minutes to be consistent with the survey median.

The RUC discussed the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy as it relates to the post-service time for the survey code. This policy excludes inclusion of inpatient visit codes in the global payment for services that are typically reported as outpatient services. CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as 23-hour stay outpatient services. In the CY2011 Final Rule, CMS finalized a policy to no longer allow codes with outpatient claims status to include bundled subsequent inpatient hospital visits (eg 99231-99233) into the surgical global payment. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. For code 27446, per the CMS policy, the intra-service time is reallocated from the same-day E/M code 99232 to the immediate post-service time of the outpatient service (adding 20 minutes of intra-service time from 99232). Though the median survey immediate post-service time was 25 minutes, the CMS 23-hour stay policy was applied resulting in 45 total post-service minutes. The RUC recommends post-service time package 9b and, following the CMS 23-hour policy, the E/M same day visit is not shown and instead the intra-service time of 20 minutes has been added to the median survey post time of 25 minutes (total=45 minutes). In addition, following the CMS 23-hour policy, the next day final evaluation of the patient and discharge management work is indicated as a discounted 0.5 x 99238 – or one-half of an E/M service (0.64 RVUs; 19 min).

For the post-service office visits, the RUC recommends the survey median response of three total office visits: 1-99214 and 2-99213. The first office visit is typically at 2 weeks following surgery; both the estimated total time and medical decision-making support 99214. The subsequent office visits are typically at 6 weeks and 10 weeks after surgery; both the estimated total time and medical decision-making support 99213 for both

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visits. Discussion around the 99214-visit clarified that there is management of medication, particularly at that first visit when there is often increased pain that necessitates an opioid adjustment and justifies the level 4 office visit.

To justify the crosswalk value of 17.13 work RVUs, the RUC compared the survey code to the key reference service codes 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* (work RVU = 19.60, 100 minutes intra-service time and 377 minutes total time) and 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU = 22.13, 140 minutes intra-service time and 448 minutes total time) and noted that the physician work and intra-service and total time of the survey code are lower than the two reference services while the intensity of the survey code is slightly higher than either reference service. The RUC further noted that the CMS 23-hour policy impacts the intensity of work per unit time and may falsely elevate the IWPUT because, if the recommendation included the full discharge day visit time of 38 minutes rather than 19 minutes (0.5-99238) and if the 99232 hospital visit remained at the full time (40 minutes), rather than adding only 20 minutes to the immediate post service time, the total time would have been 349 minutes (similar to current value of 345), with a final IWPUT of 0.101 and WPUT of 0.049, both of which are below the current values.

In addition to the comparison to total hip arthroplasty, the RUC also compared CPT code 27446 to CPT code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 19.60, 97 minutes intra-service time and 374 minutes total time) which was recently approved by the RUC in October 2019 and re-affirmed at this meeting. The RUC noted that a value below 17.13 RVUs would create a rank order anomaly between 27446 unicompartmental knee arthroplasty (UKA) and 27447 total knee replacement (TKA). Below is a comparison of CPT codes 27446 to 27447:

	27446 (UKA)	**27447 (THA)**
Work RVU	17.13	19.60
Pre-time	70	70
Intra-time	90	97
Post-time	150	207
Total time	310	374
IWPUT	0.119	0.112
WPUT	0.055	0.052

The RUC agreed that UKA is more complex and intense than TKA for several reasons:

1. UKA is less common than TKA; default is total knee, while preserving natural structure with a partial knee when appropriate is more complex.
2. UKA has higher failure and revision rate compared to TKA (~ 2X) requiring more complex considerations for repair.
3. Smaller incisions are employed to limit injury to the quadriceps mechanism, but must still allow visualization of the other compartments to assess articular cartilage damage (which might preclude UKA and require TKA).

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4. The cruciate ligaments (ACL and PCL) are retained, compared to TKA where the ACL +/-PCL are resected; this makes exposure and stability/balancing more difficult.
5. Although basic alignment devices and cutting guides are used for the bone resection, like TKA, free-hand refinements and/or use of additional technology (e.g., computer-aided, robotic assisted) that add complexity to the procedure are typically employed.
6. In a TKA, the entire articular surface of both tibia and femur are resected and replaced; in a UKA, only part of the joint is resected and replaced; alignment of the prosthetic surface with the native articular cartilage is required which adds complexity.

For additional support, the RUC compared CPT code 27446 to MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time and 283 minutes total time) and 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service time and 337 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation. The RUC concluded that CPT code 27446 should be valued based on a direct work RVU crosswalk to CPT code 67108 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 17.13 for CPT code 27446.**

Affirm RUC Recommendations
The RUC affirms its October 2019 work RVU recommendation of 19.60 for CPT code 27447.

Office Visits Included in Codes with a Surgical Global Period
The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. The RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the 2021 office visit increases to the office visits included in surgical global payment, as it has done historically.

Practice Expense
The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that the clinical work involved in the service had changed. Based on acceptance of compelling evidence, the PE Subcommittee carefully considered the clinical staff activities and discussed the specialty society recommendation of an additional 15 minutes for CA002 *Coordinate pre-surgery services (including test results)* and CA004 *Provide pre-service education/obtain consent*. The PE Subcommittee noted that the standard pre-service time package is 60 minutes for 090-day global period services and questioned the justification for the additional preclinical time. After thorough discussion, the PE Subcommittee reduced the recommendation to the standard 090-day pre-service clinical staff times for CPT code 27446 and affirmed the standard times for 27447. The PE Subcommittee with guidance from the CPT Editorial Panel representative also provided some potential options for the specialties to consider capturing any additional preclinical staff time, including possibly using existing codes including the 99415 prolonged services clinical staff code (under consideration at this meeting) or alternatively, generating a new CPT code description to truly capture the additional work. **The RUC recommends the direct practice expense inputs for CPT code 27446 as modified by the PE Subcommittee**.

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The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs for CPT code 27447 from October 2019 without modification. **The RUC recommends the direct practice expense inputs for CPT code 27447 as affirmed by the Practice Expense Subcommittee.**

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	090	17.13
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	090	19.60 (Affirmed October 2019 RUC recommendation)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27446 Tracking Number Original Specialty Recommended RVU: **17.13**
Presented Recommended RVU: **17.13**
Global Period: 090 Current Work RVU: **17.48** RUC Recommended RVU: **17.13**

CPT Descriptor: Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old obese female (BMI > 30) with osteoarthritis of the knee joint presents with increased varus of the right knee affecting activities of daily living. She is a non-insulin-dependent diabetic. At operation, she undergoes a unicompartmental knee replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 87% , In the ASC 13%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 27% , Overnight stay-less than 24 hours 64% , Overnight stay-more than 24 hours 9%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: The appropriate antibiotic(s) are selected and ordered; timing and administration are confirmed. Appropriate selection, timing and administration of DVT prophylaxis are assured. Appropriate selection of preemptive multimodal analgesic medications performed and timing and admistration are confirmed in conjunction with coordination of supplemental regional blocks and/or planned local anesthetic infiltration. Results of preadmission testing are reviewed, including laboratory tests, X rays, CT scans, and/or MRIs, with special attention to radiographs and scaled radiographs that were used for sizing and ordering of special implants. The patient is re-examined to make sure that physical findings have not changed and history and physical are updated. The patient and family are met with to review planned procedure and postoperative management, including an opioid sparing pain management protocol. Informed consent is reviewed with the patient. It is verified that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy. It is ensured that an array of implants is available for possible use in the operating room. An estimate of the appropriate-size component is determined by templating with radiographs. The patient is positioned, bony prominences are padded, and thermal regulation drapes are applied. The position of the extremities and head are assessed and adjusted as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. A tourniquet is placed on the proximal thigh. Areas of skin to be prepared are indicated, and surgical incisions are marked. A surgical "time out" is performed with the operating surgical team.

Description of Intra-Service Work: After limb exsanguination, the tourniquet is elevated. An appropriate incision for unicompartmental knee arthroplasty is used. After exposure, the knee is carefully inspected visually for the presence of arthritis in the two nonoperative compartments. The ACL is inspected and tested. The remnant meniscus and the osteophytes of the operative compartment are removed. The tibia is exposed sufficiently to allow proximal (usually medial) resection of the tibia without injury to the ACL, PCL, or MCL. After adequate distal femoral resection has been made, the femur is sized, and the appropriate jig to complete the posterior and posterior chamfer cut is used to cut and drill the femur. Posterior femoral osteophytes can then be removed. Then the improved visualization allows proper sizing and preparation of the tibial surface. Once the trial implants have been placed, a complete examination of the alignment, ligamentous balance, range of motion, and patellar tracking is done. The appropriate implants are then selected. The knee is prepared for cementing with careful retractor placement, pulsatile lavage, and suction to dry the cut bony surface. Cement is applied to the tibial surface, and the tibial component is impacted. Excess cement is then removed from the posterior tibial recess. Then the femoral component is cemented as well. A trial polyethylene is used to pressurize the components onto the bony surface. After the cement has cured, excess cement is carefully removed from around the components. Then the correct

polyethylene is placed, the knee is again tested, the tourniquet is deflated, and hemostasis is achieved. The knee wound is closed in layers

Description of Post-Service Work:

Immediate postoperative work through discharge from recovery room includes: Application of sterile dressings; removal of drapes; assessing limb alignment compared to the opposite extremity; assessing limb perfusion and pulses; waiting for reversal of anesthesia and extubation; assisting in transfer of the patient from the OR table to a stretcher or bed; assisting in transport of patient from operating room to recovery room; monitoring patient stabilization in the recovery room; completing a careful neurologic and vascular examination of the extremity; discussing postoperative recovery care with anesthesia and nursing staff, including regional blocks discussing procedure and outcome with patient and family and answering questions; entering a brief operative note and a full operative report in the medical record; calling referring physician and/or sending a copy of the operative note; writing comprehensive orders for PACU and floor care; completing medication reconciliation; ordering and reviewing postoperative radiographs; and entering procedure data, including implant details, into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

Hospital visit #1 (day of surgery later in the day) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing vital signs, I/O, labs, and other related data; reviewing findings and outcome with patient and/or family; assessing pain control and response to current medications; modify orders accordingly; assessing urinary function; examining the surgical site; reinforce dressing as needed; assessing limb position and alignment, repositioning the limb needed ; checking neurovascular status; counseling the patient and/or family regarding therapy protocol; answer questions; counseling the patient and/or family regarding OOB/ambulation, incentive spirometry, upright position in bed and use of sequential compressive devices; communicating and coordinating care with medical consult and other physicians; communicating and coordinating pain control with anesthesia, including status of current modalities (eg, blocks); updating orders; and writing “postoperative check” progress note.

Hospital discharge management (postoperative day #1) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing PT/OT notes; discussing status and progress with PT/OT staff; reviewing discharge plan notes; discussing status and progress with case management; finalizing and confirming discharge plans; reviewing notes from other physicians and discussing as appropriate; reviewing vital signs, I/O, labs and other related data; interviewing patient and obtaining interval history; assessing pain control and response to current medications; assessing gastrointestinal and urinary function; examining surgical site; changing dressing as needed; assessing limb alignment and ROM; checking neurovascular status; repositioning limb as needed; finalizing and confirming discharge plans with patient and/or family; counselling patient and/or family regarding therapy protocol and activity limitations after discharge; reviewing postoperative instructions (eg, wound care, pain medications, VTE prophylaxis); completing daily progress note; completing discharge summary and associated forms and documents; writing prescriptions for medications and devices (eg, walker, wheelchair, bedside commode, raised toilet seat); checking narcotic prescription registries; writing orders for discharge home.; completing medication reconciliation; coordinate postoperative appointment with patient and/or family and office staff; communicating and coordinating follow-up care with other physicians; and entering postoperative data into longitudinal outcome databases or registries (eg, NSQIP, AJRR).

Post-operative office visits: the work is performed by the physician and QHP; the detailed times are provided in the supplementary table.

Office visit #1 (99214): this visit typically occurs 2 weeks after surgery.

Review PT/OT and/or rehab/SNF/VNA notes to assess progress with therapy; review results of labs related to anticoagulation for DVT prophylaxis (e.g. INR, Hb, Plts); to assess therapeutic response and/or monitor for side effects; discuss findings at surgery, review procedure details and answer questions; review post-operative radiographs with patient and/or family; interview patient and obtain history and/or review data obtained by clinical staff; assess pain control, response to current medications and side-effects; assess function, mobility and progress with ambulation and compare with reports from PT/OT/rehab; discuss gastrointestinal and urinary function to assess for medication side effects; remove dressing; examine surgical site; assess limb alignment, swelling, strength and ROM; check neurovascular status; remove sutures or staples; apply steri-strips, sterile dressing and compressive wrap or stockings; counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation); counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet; Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering; check narcotic prescription registries; write order for narcotic prescription, re-fill or new medication; write order

for non-narcotic prescription as appropriate (e.g. NSAIDs, gabapentin); write order for prescriptions for continued VTE prophylaxis based on patient risk assessment and mobilization, re-fill or new medication; vomplete medication reconcillation; counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression; complete forms/referrals for continued PT/OT and/or home care services (e.g. VNA); complete disability, FMLA, out of/return to work and other related forms; communicate and coordinate care with other physicians and health care providers (eg, PT/OT, PCP); enter diagnosis code(s) and office visit codes in the EHR or other similar system; write or dictate and sign progress note; enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry).

Office visit #1: Level of service determination based upon medical decision making (LOS = 99214)

(1) Number and complexity of problems = MODERATE: 1 chronic illness (osteoarthritis of knee) with side effects (pain and limited mobility) of treatment (surgery) is assessed and managed; OR 1 acute complicated injury (surgical trauma) is assessed and managed, including body systems that are not directly part of the injured organ (e.g. GI, neurologic, vascular); treatment options are associated with morbidity

(2) Amount and complexity of data = LIMITED: review external notes and review results of tests

(3) Risk of complications from testing and/or treatment = MODERATE: (a) prescription drug management - assessment and plan for multi-modal pain management, including use of narcotic pain medication with tapering, as well as non-narcotic medicationsrenew, adjust and/or change medications; (b) prescription drug management - assessment and plan for VTE prophylaxis; renew, adjust and/or change medications

Post-operative office visit #2 (99213): this visit typically occurs six weeks after surgery

Review PT/OT notes to assess progress with therapy; interview patient and obtain history and/or review data obtained by clinical staff; assess pain control, response to current medications and side-effects; assess function, mobility and progress with ambulation and compare with reports from PT/OT; assess gastrointestinal to assess for medication side effects; examine surgical site to assess wound healing and signs of infection; assess limb alignment, swelling, strength and ROM; counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation); counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics and provide/review instruction sheet; counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering; write order for non-narcotic prescription as appropriate (e.g. NSAIDs); complete medication reconcillation; counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression; complete forms/referrals for continued PT/OT; complete disability, FMLA, out of/return to work and other related forms; enter diagnosis code(s) and office visit codes in the EHR or other similar system; order radiographs for next visit; write or dictate and sign progress note; enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry).

Office visit #2: Level of service determination based upon medical decision making (LOS = 99213)

(1) Number and complexity of problems = LOW: stable chronic illness (knee osteoarthritis) or acute uncomplicated illness (major surgery)

(2) Amount and complexity of data = LIMITED: review external notes and ordering test (radiographs)

(3) Risk of complications from testing and/or treatment = LOW; non-narcotic medications and PT

Post-operative office visit #3 (99213): this visit typically occurs 10 weeks after surgery

Review PT/OT notes to assess progress with therapy; interview patient and obtain history and/or review data obtained by clinical staff; assess pain control, response to current medications and side-effects; assess function, mobility and progress with ambulation and compare with reports from PT/OT; examine surgical site to assess wound healing and signs of infection; assess limb alignment, swelling, strength and ROM; review radiographs with independent interpretation; counsel patient and/or family regarding therapy protocol and activity (e.g. driving, exercise, sports); counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics and provide/ review instruction sheet; counsel patient/family regarding timing of next office visit and communicate interval care plan

based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression; complete forms/referrals for continued PT/OT; complete disability, FMLA, out of/return to work and other related forms; enter diagnosis code(s) and office visit codes in the EHR or other similar system; write or dictate and sign progress note; enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)

Office visit #3: Level of service determination based upon medical decision making (LOS = 99213)

(1) Number and complexity of problems = LOW: stable chronic illness (knee osteoarthritis) or acute uncomplicated illness (major surgery)

(2) Amount and complexity of data = MODERATE: review external notes, review results of tests (radiographs) and independent interpretation of test (radiographs)

(3) Risk of complications from testing and/or treatment = LOW: non-narcotic medications and PT

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Adolph Yates, MD; William Creevy, MD; Hussein Elkousy, MD					
Specialty Society(ies):	AAHKS, AAOS					
CPT Code:	27446					
Sample Size:	1317	**Resp N:**	126			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**12.00**	30.00	400.00	
Survey RVW:	14.50	18.60	**19.60**	21.00	25.69	
Pre-Service Evaluation Time:			**45.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	40.00	68.00	**90.00**	90.00	180.00	
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	27446	**Recommended Physician Work RVU: 17.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27130	090	19.60	**RUC Time**

CPT Descriptor Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23472	090	22.13	**RUC Time**

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.00	**RUC Time**	25,487

CPT Descriptor 1 Mastectomy, simple, complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	10,340

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	Global	Work RVU	Time Source
67107	090	16.00	**RUC Time**

CPT Descriptor Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 71 **% of respondents:** 56.3 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 27446	Top Key Reference CPT Code: 27130	2nd Key Reference CPT Code: **23472**
Median Pre-Service Time	70.00	70.00	75.00
Median Intra-Service Time	90.00	100.00	140.00
Median Immediate Post-service Time	45.00	20.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	80.00	80.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	86.0	69.00	85.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**310.00**	**377.00**	**448.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	59%	27%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	58%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	38%	49%	13%
Physical effort required	8%	61%	31%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	58%	34%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	81%	14%	5%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	81%	19%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	76%	19%
Physical effort required	0%	81%	19%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	76%	24%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the Relativity Assessment Workgroup (RAW) flagged code 27446 as including inpatient E/M visits from the RUC review in 2013, but 2019 Medicare utilization showed the procedure being performed less than 50% of the time with an inpatient facility status. The RAW recommended that 27446 be surveyed.

At the January 2021 RUC meeting, AAOS and AAHKS submitted a letter indicating code 27446 would be surveyed for the April 2021 meeting after the Research Subcommittee reviewed a revised survey instrument to address additional preoperative time and resources.

During discussion, the RUC also asked the societies to present a recommendation for reaffirmation of code 27447.

The societies instead requested that 27447 be allowed on the reference service list since this code was surveyed in 2019 and the RUC recommendation was accepted and implemented by CMS in 2021.

However, the RUC asked that the code not be listed on the RSL and that the data for the code be included in the recommendation for re-affirmation.

Recommendation – 27446

The survey median work RVU of 19.60 and the 25th percentile work RVU of 18.60 are both above the current work RVU of 17.48 for code 27446. There is no compelling evidence to support an increase in work RVU.

The intraoperative time of 90 minutes for this procedure has not changed with the new survey.

Although there is a decrease of one day in the hospital, there is an increase in the level of office visits.

We recommend work RVU of 17.13 using a direct crosswalk to code 67108, *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique,* which was surveyed in 2015 and has the same intra-service time as 27446 and similar total time.

CPT code 27446 requires more pre-service and more same-day post-operative work; while CPT code 67108 has a greater number of post-operative visits. The intra-service times are exactly the same. The total times are quite similar – 310 minutes for 27447 and 295 minutes for 67108.

The following table compares 27446 and 67108:

	Crosswalk Comparison	
	27446	**67108**
	Uni-knee joint replacement	Repair retinal detachment
wRVU	17.13	17.13
2019 Utilization	15,803	16,523
Facility Status	typically admitted or overnight	typically same-day discharge
Inpatient	31%	<1%
Outpatient Hosp	31%	52%
ASC	18%	46%
Pre-time	70 (package 4)	51 (package 3)
Intra-time	90	90
Immed post time	45	20
Other Hosp time	0[1]	0
Discharge day	0.5 x 99238[2]	0.5 x 99238[3]
Office visit time	86	115
Total time	310	295
IWPUT	0.119	0.114
WPUT	0.055	0.058

Notes:
1. Separate hospital E/M visit time discounted and shifted to immediate post-time component
2. Next day (or later) discharge management work discounted by 50%
3. Discharge management work discounted due to overlap with immediate postop time on same day

Pre-Service Time

We recommend package 4 for pre-service package time which is the current pre-service package.

Adjustments have been made to the package times for evaluation and scrub/dress/wait time to be consistent with the survey median times.

Twelve minutes have been added to the standard package time of 3 minutes (total of 15 minutes) to assist with positioning the patient, pad bony prominences, and apply thermal regulation drapes; assess position of the extremities and head and adjust as needed; place patient's leg properly on the table and position with proper bolstering to aid surgical exposure; place a tourniquet on the proximal thigh; confirm tourniquet settings and validate function. This is consistent with both the survey median and historical RUC precedent for many similar orthopaedic codes for extremity operations.

Intraoperative (Intraservice) Time

The societies recommend 90 minutes intraoperative time, which is the survey median. This is also the current intraoperative time

Post-Service Facility Work

The societies recommend Immediate Post-Service package 9b but following the CMS 23-hour policy, the E/M same day visit is not shown and instead the intraservice time of 20 minutes has been added to the median survey post time of 25 minutes (total=45 minutes). In addition, following the CMS 23-hour policy, the next day final evaluation of the patient and discharge management work is indicated as a discounted 0.5 x 99238 – or one-half of an E/M service.

The RUC has accepted what we believe to be a flawed 23-hour policy for (a) adding only the intra-time for the same day post-operative visit to the immediate post-service time and (b) allowing only 50% of the time for discharge day service code 99238. However, the full and complete E/M work is still provided the day of surgery and the day of discharge. This adjustment of survey data results in an artificial increase in the IWPUT, which alone cannot be the basis for a work RVU recommendation.

A facility E/M visit is not just intra-service time, there is typically pre- and post-service work necessary for review of records, documentation and discussions with family and other health care providers. Similarly, on the next day for an overnight stay after surgery, the final evaluation and discharge management work is not less work compared with a patient on the medicine service. If there were any logic and consistency to this policy, then a physician should only be able to report one-half unit of a discharge code for next day discharge after an overnight stay for observation – but instead the physician reports a full unit of the code. We believe that postoperative work by the surgeon is being inappropriately discounted.

If our recommendation included the full discharge day visit time of 38 minutes rather than 19 minutes (0.5 x 99238) and if we kept the 99232 hospital visit at the full time (40 minutes), rather than deleting it and adding only 20 minutes to the immediate post service time, the final time would have been 349 minutes (similar to current value of 345), with a final IWPUT of 0.101 and WPUT of 0.049, both of which are below the current values.

If we included a full discharge day service for 99238 (38 minutes), but maintained the transfer of only 20 minutes for 99232 to the immediate post-service time, the final time would have been 329 minutes, with an IWPUT of 0.112 and WPUT of 0.052. These values are similar to the current values.

In essence, the increases in IWPUT and WPUT for our recommended value of 17.13, are an artifact of the current RUC methodology and is not reflective of the intrinsic intensity and complexity inherent to the procedure.

Post-Service Office Visits

The societies recommend the survey median response of three total office visit; 1 x 99214 and 2 x 99213. These visits are described in the post-service description of work.

The work at the post-operative office visits is typically performed by the physician and QHP. The total estimated times listed in the supplementary tables below reflect this combined work.

The first office visit is typically at 2 weeks following surgery; both the estimated total time and medical decision-making support 99214.

The subsequent office visits are typically at 6 weeks and 10 weeks after surgery; both the estimated total time and medical decision-making support 99213 for both visits.

Tables With Estimated Times For Office Visits

OFFICE VISIT #1: two weeks after surgery (LOS = 99214)		
Work completed by the physician and/or QHP		**Minutes**
1.	Review PT/OT and/or rehab/SNF/VNA notes to assess progress with therapy	1-2
2.	Review results of labs related to anticoagulation for DVT prophylaxis (e.g. INR, Hb, Plts); to assess therapeutic response and/or monitor for side effects	1-2
3.	Discuss findings at surgery and review procedure details; answer questions	2
4.	Review post-operative radiographs with patient and/or family	
5.	Interview patient and obtain history and/or review data obtained by clinical staff	2-3
6.	Assess pain control, response to current medications and side-effects	
7.	Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
8.	Assess gastrointestinal and urinary function to assess for medication side effects	
9.	Remove dressing; examine surgical site	3-3
10.	Assess limb alignment, swelling, strength and ROM	
11.	Check neurovascular status	
12.	Remove sutures or staples; apply steri-strips, sterile dressing and compressive wrap or stockings	4
13.	Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)	3
14.	Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet	
15.	Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering	
16.	Check narcotic prescription registries	4
17.	Write order for narcotic prescription; re-fill or new medication	
18.	Write order for non-narcotic prescription as appropriate (e.g. NSAIDs, gabapentin)	
19.	Write order for prescriptions for continued VTE prophylaxis based on patient risk assessment and mobilization; re-fill or new medication	
20.	Complete medication reconcillation	
21.	Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
22.	Complete forms/referrals for continued PT/OT and/or home care services (e.g. VNA)	2-3
23.	Complete disability, FMLA, out of/return to work and other related forms	
24.	Communicate and coordinate care with other physicians and health care providers (e.g., PT/OT, PCP)	2-3
25.	Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
26.	Write or dictate and sign progress note	
27.	Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
	TOTAL TIME	**32-40**
	REQUIRED TIME	**30-39**

OFFICE VISIT #2: six weeks after surgery (LOS = 99213)		
Work completed by the physician and/or QHP		**Minutes**
1.	Review PT/OT notes to assess progress with therapy	1-2
2.	Interview patient and obtain history and/or review data obtained by clinical staff	3
3.	Assess pain control, response to current medications and side-effects	
4.	Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
5.	Assess gastrointestinal to assess for medication side effects	
6.	Examine surgical site; assess wound healing and signs of infection	2-3
7.	Assess limb alignment, swelling, strength and ROM	
8.	Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)	3
9.	Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet	
10.	Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering	

11.	Write order for non-narcotic prescription as appropriate (e.g. NSAIDs)	2-3
12.	Complete medication reconcillation	
13.	Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
14.	Complete forms/referrals for continued PT/OT	2-3
15.	Complete disability, FMLA, out of/return to work and other related forms	
16.	Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
17.	Order radiographs for next visit	
18.	Write or dictate and sign progress note	
19.	Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
	TOTAL TIME	**21-27**
	REQUIRED TIME	**20-29**

OFFICE VISIT #3: ten weeks after surgery (LOS = 99213)		
Work completed by the physician and/or QHP		**Minutes**
1.	Review PT/OT notes to assess progress with therapy	1-2
2.	Interview patient and obtain history and/or review data obtained by clinical staff	3
3.	Assess pain control, response to current medications and side-effects	
4.	Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
5.	Examine surgical site; assess wound healing and signs of infection	2-3
6.	Assess limb alignment, swelling, strength and ROM	
7.	Review radiographs; independent interpretation	2-3
8.	Counsel patient and/or family regarding therapy protocol and activity (e.g. driving, exercise, sports)	2-3
9.	Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet	2-3
10.	Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
11.	Complete forms/referrals for continued PT/OT	2-3
12.	Complete disability, FMLA, out of/return to work and other related forms	
13.	Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
14.	Write or dictate and sign progress note	
15.	Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
	TOTAL TIME	**22-29**
	REQUIRED TIME	**20-29**

Comparison to Total Knee Arthroplasty (27447)

Total knee arthroplasty (27447) was recently approved by the RUC in October 2019 and will be re-affirmed at this meeting.

CPT code 27447 was not permitted to be on the RSL, so survey respondents did not compare 27446 to 27447.

The table below compares 27446 (unicompartmental knee arthroplasty) to 27447 (total knee arthroplasty).

	27446 (UKA)	27447 (THA)
wRVU	17.13	19.60
Pre-time	70	70
Intra-time	90	97
Post-time	150	207
Total time	310	374
IWPUT	0.119	0.112
WPUT	0.055	0.052

The IWPUT of 0.119 for 27446 is greater than 27447 (TKA) of 0.112.

We believe UKA is in fact more complex and intense than TKA for several reasons:

1. UKA is less common than TKA; Medicare volume in 2019 was 20X for TKA v UKA
2. UKA has higher failure and revision rate compared to TKA (~ 2X)
3. Smaller incisions are employed to limit injury to the quadriceps mechanism, but must still allow visualization of the other compartments to assess articular cartilage damage (which might preclude UKA and require TKA)
4. The cruciate ligaments (ACL and PCL) are retained, compared to TKA where the ACL +/-PCL are resected; this makes exposure and stability/balancing more difficult
5. Although basic alignment devices and cutting guides are used for the bone resection, similar to TKA, free-hand refinements and/or use of additional technology (e.g. computer-aided, robotic assisted) are typically employed
6. In a TKA, the entire articular surface of the both tibia and femur are resected and replaced; in a UKA, only part of the joint is resected and replaced; alignment of the prosthetic surface with the native articular cartilage is required

A value below 17.13 would create a ***rank order anomaly*** with 27447 (TKA).

Key Reference Code Comparison

Respondents who chose 27130 as a reference indicated the intensity/complexity of 27446 to be similar/more complex and intense than 27130. Respondents who chose 23472 as a reference indicated the intensity/complexity of 27446 to be similar/more than 23472.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	17.13	0.119	310	70	90	150
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	19.60	0.109	377	70	100	207
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)).	22.13	0.089	448	75	140	233

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
19303	Mastectomy, simple, complete	15.00	0.102	283	58	90	135
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	17.13	0.119	310	70	90	150
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	17.75	0.109	322	80	103	139

Other Code Comparison

Codes 63620 and 67108 bracket and offer further support of the recommended wRVU of 17.13 for 27446.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	15.60	0.136	195	25	90	80
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	17.13	0.119	310	70	90	150
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	17.13	0.114	295	51	90	154

Summary

The survey data is valid and robust.

The current wRVU is greater than the median and 25th percentile; there is no compelling evidence for an increase.

Given the decrease in total time (which we believe has methodological flaws and is artificially low), we do not recommend maintaining the current value.

We recommend the cross walked wRVU of 17.13, which takes into account three key considerations:

(1) No change in intraoperative time
(2) One day less of hospital E/M work
(3) Increase level of postoperative office work

Work RVU below 17.13 would create a rank order anomaly with CPT code 27447 (total knee replacement).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27446

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopedic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
15,803 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty orthopaedic surgery Frequency 15567 Percentage 98.50 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Orthopedic - Knee replacement

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 27446

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

Tables With Estimated Times For Office Visits

OFFICE VISIT #1: two weeks after surgery (LOS = 99214)		
Work completed by the physician and/or QHP		**Minutes**
28.	Review PT/OT and/or rehab/SNF/VNA notes to assess progress with therapy	1-2
29.	Review results of labs related to anticoagulation for DVT prophylaxis (e.g. INR, Hb, Plts); to assess therapeutic response and/or monitor for side effects	1-2
30.	Discuss findings at surgery and review procedure details; answer questions	2
31.	Review post-operative radiographs with patient and/or family	
32.	Interview patient and obtain history and/or review data obtained by clinical staff	2-3
33.	Assess pain control, response to current medications and side-effects	
34.	Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
35.	Assess gastrointestinal and urinary function to assess for medication side effects	
36.	Remove dressing; examine surgical site	3-3
37.	Assess limb alignment, swelling, strength and ROM	
38.	Check neurovascular status	
39.	Remove sutures or staples; apply steri-strips, sterile dressing and compressive wrap or stockings	4
40.	Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)	3
41.	Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet	
42.	Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering	
43.	Check narcotic prescription registries	4
44.	Write order for narcotic prescription; re-fill or new medication	
45.	Write order for non-narcotic prescription as appropriate (e.g. NSAIDs, gabapentin)	
46.	Write order for prescriptions for continued VTE prophylaxis based on patient risk assessment and mobilization; re-fill or new medication	
47.	Complete medication reconcillation	
48.	Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
49.	Complete forms/referrals for continued PT/OT and/or home care services (e.g. VNA)	2-3
50.	Complete disability, FMLA, out of/return to work and other related forms	
51.	Communicate and coordinate care with other physicians and health care providers (e.g., PT/OT, PCP)	2-3
52.	Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
53.	Write or dictate and sign progress note	
54.	Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
	TOTAL TIME	**32-40**
	REQUIRED TIME	**30-39**

OFFICE VISIT #2: six weeks after surgery (LOS = 99213)		
Work completed by the physician and/or QHP		**Minutes**
20.	Review PT/OT notes to assess progress with therapy	1-2
21.	Interview patient and obtain history and/or review data obtained by clinical staff	3
22.	Assess pain control, response to current medications and side-effects	
23.	Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
24.	Assess gastrointestinal to assess for medication side effects	
25.	Examine surgical site; assess wound healing and signs of infection	2-3
26.	Assess limb alignment, swelling, strength and ROM	
27.	Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)	3
28.	Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental,	

	GI) about need for prophylactic antibiotics; review instruction sheet	
29.	Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering	
30.	Write order for non-narcotic prescription as appropriate (e.g. NSAIDs)	2-3
31.	Complete medication reconcillation	
32.	Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
33.	Complete forms/referrals for continued PT/OT	2-3
34.	Complete disability, FMLA, out of/return to work and other related forms	
35.	Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
36.	Order radiographs for next visit	
37.	Write or dictate and sign progress note	
38.	Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
	TOTAL TIME	**21-27**
	REQUIRED TIME	**20-29**

OFFICE VISIT #3: ten weeks after surgery (LOS = 99213)	
Work completed by the physician and/or QHP	**Minutes**
16. Review PT/OT notes to assess progress with therapy	1-2
17. Interview patient and obtain history and/or review data obtained by clinical staff	3
18. Assess pain control, response to current medications and side-effects	
19. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab	
20. Examine surgical site; assess wound healing and signs of infection	2-3
21. Assess limb alignment, swelling, strength and ROM	
22. Review radiographs; independent interpretation	2-3
23. Counsel patient and/or family regarding therapy protocol and activity (e.g. driving, exercise, sports)	2-3
24. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet	2-3
25. Counsel patient/family regarding timing of next office visit and communicate interval care plan based on synthesis of interval history, physical exam, wound assessment, pain control and therapy progression	2-3
26. Complete forms/referrals for continued PT/OT	2-3
27. Complete disability, FMLA, out of/return to work and other related forms	
28. Enter diagnosis code(s) and office visit codes in the EHR or other similar system	4
29. Write or dictate and sign progress note	
30. Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)	2-3
TOTAL TIME	**22-29**
REQUIRED TIME	**20-29**

ISSUE: Knee Arthroplasty

TAB: 18

	Review							RVW					Total	PRE			INTRA					IMMD	POST Facility						POST-Office					12 Month Svy Experience				
SOURCE	Year	CPT	DESC	Glob	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
REF1	2019	27130	Arthroplasty, acetabular and proximal femoral pr	90	71	0.108	0.052			19.60			377	40	15	15			100			20			2			1.0			3								
REF2	2012	23472	Arthroplasty, glenohumeral joint; total shoulder (g	90	21	0.089	0.049			22.13			448	40	15	20			140			30			1	2		1.0			3	1							
Current	2013	27446	Arthroplasty, knee, condyle and plateau; medial (	90		0.109	0.051			17.48			345	40	15	20			90			20			1	1		1.0			2	1							
SVY	2021	27446	Arthroplasty, knee, condyle and plateau; medial (	90	126	0.127	0.055	14.50	18.60	19.60	21.00	25.69	354	45	15	15	40	68	90	90	180	25			1			1.0			1	2			0	5	12	30	400
REC		27446	crosswalk to RVW for 67108	90		0.119	0.055			17.13			310	40	15	15			90			45						0.5			1	2							
XWALK	2015	67108	Repair of retinal detachment; with vitrectomy, any	90		0.114	0.058			17.13			295	33	3	15			90			20						0.5			5								

AFFIRM

Current	2019	27447	Arthroplasty, knee, condyle and plateau; medial /	90		0.112	0.052			19.60			374	40	15	15			97			20			2			1.0			3								

FACILITY DIRECT PE INPUTS **CPT CODE(S): 27446, 27447**
SPECIALTY SOCIETY(IES):AAOS, AAHKS
PRESENTER(S): Adolph Yates, MD; William Creevy, MD; Hussein Elkousy, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 04/2021

CPT Code	Long Descriptor	Global Period
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	090
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
27446	A 67-year-old obese female (BMI > 30) with osteoarthritis of the knee joint presents with increased varus of the right knee affecting activities of daily living. She is a non-insulin-dependent diabetic. At operation, she undergoes a unicompartmental knee replacement.
27447	A 74-year-old female has knee osteoarthritis not responding to nonoperative treatment. A total knee arthroplasty (TKA) is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
   A panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):
   Current codes are used for reference.

3. Is this code(s) typically reported with an E/M service?
   NO

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms	Staff reviews all forms with patient and/or caregiver to ensure all relevant history and diagnostic information is included
Coordinate pre-surgery services (including test results)	Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, reviews patient medical status, confirms preoperative cleansing protocol, and answers final pre-admission questions.

   b. Service period (includes pre, intra and post):

6 minutes (standard)
Office clinical staff will assist with necessary post-discharge care via phone or electronically, such as: responding to patient/family questions about home activity restrictions; confirmation of discharge antibiotics if needed, and pain medication; coordination with other physicians and QHPs involved in the care of the patient for transfer of records; and transitioning discharge information to the surgeon's office medical record, including medication list, correspondence and imaging or lab results pending at discharge.

-

   c. Post-service period:

125 minutes - standard time for <u>current</u> (2021) office visit E/Ms
Clinical staff will greet the patient, provide gowning, and ensure that all appropriate medical records are available including interval imaging and labs, physical therapy reports, and chart notes from other physicians. Clinical staff will obtain vital signs, prepare the room and necessary supplies, assist with patient positioning for exam, review and document history, systems and medications. Clinical staff will assist the physician during the exam which may include wound and drain (if present) assessment, neurovascular assessment, ROM assessment, and staple removal when appropriate. Clinical staff will clean the room and answer any patient/family questions about home care including activity limitations and reinforcement of physical therapy activities. Clinical staff will assist the physician

with orders for medication and physical therapy changes. Clinical staff will assist with answering patient, family, caregiver, therapist, other clinician questions and help process changes in care.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

SA048	pack, minimum multi-specialty visit
SA052	pack, post-op incision care (staple)

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, post-op incision care (staple)	**SA052**	**pack**		**4.864**
kit, staple removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

n/a

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031	table, power	Time is equal to office visit total time based on 2019 E/M visit time – not based on actual E/M visit time.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise

the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT (October 2019 RUC Approved)**	
2						**27446**		**27446**		**27447**	
3	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAOS, AAHKS** **(Affirmation of PE inputs for 27447 from October 2019 RUC)**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment		Arthroplasty, knee, condyle and plateau; medial OR lateral compartment		Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with	
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**	**090**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**171.0**	**0.0**	**191.0**	**0.0**	**180.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**99.0**	**0.0**	**125.0**	**0.0**	**108.0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
12		**PRE-SERVICE PERIOD**									
13		**Start: Following visit when decision for surgery/procedure made**									
14	CA001		L037D				5		5		5
15	CA002		L037D				20		20		20
16	CA003		L037D				8		8		8
17	CA004		L037D				20		20		20
18	CA005		L037D				7		7		7
28		**End: When patient enters office/facility for surgery/procedure**									
29		**SERVICE PERIOD**									
30		**Start: When patient enters office/facility for surgery/procedure:**									
73	CA036		L037D			**n/a**	**12**	**n/a**	**6**	**n/a**	**12**
80		**End: Patient leaves office/facility**									
81		**POST-SERVICE PERIOD**									
82		**Start: Patient leaves office/facility**									
85		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
86		99211 16 minutes	16								
87		99212 27 minutes	27				1				
88		99213 36 minutes	36				2		2		3
89		99214 53 minutes	53						1		
90		99215 63 minutes	63								
91	CA039		L037D			**0.0**	**99.0**	**0.0**	**125.0**	**0.0**	**108.0**
98		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT (October 2019 RUC Approved)**	
2						**27446**		**27446**		**27447**	
3	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAOS, AAHKS** **(Affirmation of PE inputs for 27447 from October 2019 RUC)**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment		Arthroplasty, knee, condyle and plateau; medial OR lateral compartment		Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with	
4		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**	**090**
6		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7		**TOTAL CLINICAL STAFF TIME**	L037D			**0.0**	**171.0**	**0.0**	**191.0**	**0.0**	**180.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**0.0**	**99.0**	**0.0**	**125.0**	**0.0**	**108.0**
99	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
100		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
101	SA048						3		3		3
102	SA052						1		1		1
103											
109	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
111	EF031			Office Visits			99.0		125.0		108.0
112											

	A	B	M	N
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of Oct 2019 Inputs)	
2			27447	
3	Clinical Activity Code	Meeting Date: 04/2021 Revision Date (if applicable): Tab: 18 Specialty: AAOS, AAHKS (Affirmation of PE inputs for 27447 from October 2019 RUC)	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella	
4		LOCATION	Non Fac	Facility
5		GLOBAL PERIOD	090	090
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -
7		TOTAL CLINICAL STAFF TIME	0.0	180.0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	60.0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	12.0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	108.0
11		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -
12		PRE-SERVICE PERIOD		
13		Start: Following visit when decision for surgery/procedure made		
14	CA001			5
15	CA002			20
16	CA003			8
17	CA004			20
18	CA005			7
28		End: When patient enters office/facility for surgery/procedure		
29		SERVICE PERIOD		
30		Start: When patient enters office/facility for surgery/procedure:		
73	CA036		n/a	12
80		End: Patient leaves office/facility		
81		POST-SERVICE PERIOD		
82		Start: Patient leaves office/facility		
85		*Office visits: List Number and Level of Office Visits*	# visits	# visits
86		99211 16 minutes		
87		99212 27 minutes		
88		99213 36 minutes		3
89		99214 53 minutes		
90		99215 63 minutes		
91	CA039		0.0	108.0
98		End: with last office visit before end of global period		

	A	B	M	N
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of Oct 2019 Inputs)	
2			27447	
3	Clinical Activity Code	Meeting Date: 04/2021 Revision Date (if applicable): Tab: 18 Specialty: AAOS, AAHKS (Affirmation of PE inputs for 27447 from October 2019 RUC)	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella	
4		LOCATION	Non Fac	Facility
5		GLOBAL PERIOD	090	090
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -
7		TOTAL CLINICAL STAFF TIME	0.0	180.0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	60.0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	12.0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	108.0
99	Supply Code	MEDICAL SUPPLIES		
100		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -
101	SA048			3
102	SA052			1
103				
109	Equipment Code	EQUIPMENT		
110		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -
111	EF031			108.0
112				

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly*

January 2021

Knee Arthroplasty – Tab 27

In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The Workgroup reviewed hospital outpatient claims data to confirm that this service is typically performed in the outpatient setting without any observation or overnight stay. Of 414 carrier line items (from the 5% physician claim files) for CPT code 27446 that were matched to a hospital outpatient claim, just 44 (11 percent) appear to have involved observation care with an overnight stay. The Workgroup noted that CPT code 27446 is a site of service anomaly and visits are currently included in this service that are not typical of what is occurring. The RUC recommended that CPT code 27446 be surveyed for January 2021 with the appropriate code family.

At the January 2021 meeting, the specialty societies submitted a request to defer survey until April 2021 due to logistical reasons including timing and a desire to be placed on the Research Subcommittee agenda "to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work." It is the RUC's understanding that the specialty societies will survey the code family and develop recommendations for presentation at the April 2021 RUC meeting. The RUC notes that the family of services should be identified on the level of interest (LOI). **The RUC recommends that CPT code 27446 be surveyed for April 2021 with the appropriate code family.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	090	Request to Survey April 2021 RUC Meeting

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American Academy of Orthopaedic Surgeons
American Association of Hip and Knee Surgeons
9400 West Higgins Road
Rosemont, IL 60018-4976

December 14, 2020

Peter K. Smith, MD
Chair, AMA Relative Value Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 3930
Chicago, IL 60611-5885

Dear Dr. Smith,

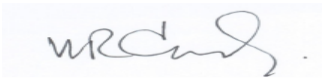
The RUC placed CPT code 27446, Arthroplasty, knee, condyle and plateau; medial OR lateral compartment on the CMS/RAW Level of Interest form for the January 2021 RUC meeting (Tab 27). 27446 was flagged by the RAW in the October 2020 RUC cycle for a site-of-service anomaly with more than 50% of current Medicare utilization outpatient . The RAW report to the full RUC automatically elevated the code to survey, without an action plan, for the January 2021 meeting.

The AAOS and AAHKS have responded to the LOI and indicated we will develop recommendations for the RUC for the code. At this time, our societies recommend survey for presentation at the April 2021 RUC meeting.

We also request at this time that CPT code 27446 be placed on the Research Committee agenda to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work.

Thank you for your time and attention and please let us know if you have any questions.

Sincerely,



William R. Creevy, MD
AAOS RUC Advisor



Adolph Yates, MD
AAHKS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Final Rule for 2019 – Public Nominations*

October 2019

Hip/Knee Arthroplasty – Tab 11

In the Final Rule for 2019, CMS indicated that seven CPT codes were nominated by Anthem for review. In its request, Anthem hypothesized a systemic overvaluation of work RVUs in certain procedures and tests based "on a number of GAO and MedPAC reports, media reports regarding time inflation of specific services, and the January 19, 2017 Urban Institute report for CMS." Anthem suggested that the physician time CMS assumes in estimating work RVUs are inaccurate for procedures, especially due to substantial overestimates of pre-service and post-service time, including follow-up inpatient and outpatient visits that do not take place. According to Anthem, the intra-time estimates for tests and some other procedures are also overstated. Anthem stated that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. The RUC noted that they recommended reductions in 2013 and CMS did not accept the RUC recommendation. However, the CMS accepted values did result in decreases of 2.53 for 27447 and 1.07 for 27130 from the current values at that time. The RUC placed these services on the LOI for review at the April 2019 RUC meeting. The specialty societies did not survey these services for April 2019 citing a lack of compelling data to justify the request and recommended maintaining the 2013 CMS values and times. At the April RUC, the RUC recommended that these services be surveyed for October 2019 and the specialty surveyed the services in the summer of 2019.

Pre-Service Work
In October 2019, the RUC discussed the change in the way total hip and knee arthroplasties are provided. Total hip and knee arthroplasty are increasingly part of a mandatory Medicare bundled payment program (Comprehensive Care for Joint Replacement [CJR]) or an optional Medicare bundled payment program (Bundled Payment for Care Initiative [BPCI]). Similar alternative payment models are employed in many states by both Medicaid and private insurers. Physicians are also more commonly participating in accountable care organizations (shared savings programs) with Medicare, Medicaid and other payors. All hospitals, regardless of participating in a bundle, are being measured for the 90-day episode of cost for total hip and knee surgery for Medicare patients, affecting both the value based program and hospital quality reporting processes. In all these programs, physicians and hospitals have financial incentives to reduce costs and improve quality.

For total joint replacement, one of the key strategies has been improving preoperative identification and optimization of medical co-morbidities to shorten hospital length of stay and reduce complications, including readmissions. In a 2019 New England Journal of Medicine (NEJM) study on the outcomes of patients in the CJR program, the mean number of chronic medical conditions was seven. Considerable work by the clinical staff, surgeons, and qualified healthcare providers (QHPs) is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. The service has also evolved in that patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

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The RUC agreed that all this work is not explicitly captured in the standard RUC survey, nor is it included in the current RUC pre-time packages, but the work is certainly being performed on a routine basis for the typical patient.

Prior to surveying, the specialty societies requested to modify the standard 090-day survey to include language regarding pre-operative planning physician time, care coordination time, non-face-to-face post-operative physician time, the impacts of bundled care initiatives (e.g., ACE demonstration, CJR, and BPCI Advanced) and clinical staff time. The specialty societies noted these arthroplasty procedures typically require additional planning time that is often performed more than 24 hours prior to the procedure. The current survey tool and CMS policy defines the pre-operative period as the day before the procedure and, therefore, precludes the survey respondent from being able account for this pre-planning time. The RUC maintains the current CMS pre-service period definition and did not modify the pre-service period question. The RUC noted that the clinical staff pre-service period time in the PE determinations begins after the decision for surgery. Therefore, the Research Subcommittee did approve a question asking how much time the clinical staff (e.g., RN, LPN, MA) spends per patient on planning, preparation, optimization and care coordination activities prior to surgery.

The specialty societies noted that the individual performing the work to prepare the patient for surgery and the processes and protocols is different in various practices or institutions. However, it is typical that the physician/QHP will spend 30 minutes after the decision for surgery but prior to surgery for these planning activities.

The RUC agreed that the pre-service planning activities occur, however the current code and 090-day global period structure is not the way to capture it. The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP. The RUC indicated that separate planning codes may be developed or the current prolonged services, CPT codes 99358 *Prolonged evaluation and management service before and/or after direct patient care; first hour* or 99359 *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)* may be reported for these activities. It was recognized that such codes are intended to capture a single episode of time and that the added work in the preoperative period does not occur in such units of time (e.g., 30 minutes in one session as opposed to over the course of a few days/calls). The RUC also noted that the additional clinical staff activities would not be captured within the prolonged service codes.

The RUC reviewed the current description of pre-service work and acknowledged additional pre-service work may be occurring. However, the specialty societies revised the description of work to include only the work of the physician or QHP on the day of surgery or the day prior to surgery.

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Median Intra-Service Time Data
Anthem's letter to CMS cited an Urban Institute study "*Collecting Empirical Physician Time Data Piloting an Approach for Validating Work Relativity Value Units*; *Zuckerman, 2016"* as part of their rationale for nominating these services as potentially misvalued. This study was based on a very limited data set. The study indicated a median of 87 minutes for total hip arthroplasty and a median of 83 minutes for total knee arthroplasty.

The specialty societies quoted three studies from large institutions on over 20,000 total hip and knee arthroplasty services, provided by over 100 surgeons, which support the current and recommended median intra-service time of 100 (THA) and 97 (TKA) minutes.

1. *Surgeon Mean Operative Times in Total Knee Arthroplasty in a Variety of Settings in a Health System; Khanuja, 2019*
    - Median Operative Time: **103 minutes (TKA)**
    - The Johns Hopkins University – 4 hospitals 2 community centers and 2 academic medical centers
    - 6,003 cases, primary TKA
    - 41 surgeons
    - EHR data from 2015-2018

2. *Is operative Time a Predictor for Post-Operative Infection in Primary Total Knee Arthroplasty?; Anis, 2019*
    - Median Operative Time: **102 minutes (TKA)**
    - Cleveland Clinic and Lenox Hill: 16 centers
    - 11,840 cases primary TKA
    - EHR data 2014-2017

3. *Average Operative Times for 1,313 Primary TKA and 1,300 TKA over 39 Months Are Roughly Equal to Medicare Attributed Operative Times; Shah, 2019*
    - Median Operative Time: **113 minutes (TKA) and 99 minutes (THA)**
    - Columbia University
    - 4 surgeons
    - Data from 2015-March 2019

27130 ***Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft***
The RUC reviewed the survey results from 206 orthopaedic and hip/knee surgeons and determined a work RVU of 19.60 appropriately accounts for the work required to perform 27130. The RUC developed this recommendation by crosswalking 27130 to the work of 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60 and 90 minutes intra-service time, 355 minutes of total time). These two services require similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform and therefore should be valued the same. For further

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support, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU = 19.44 and 100 minutes intra-service time), 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35 and 90 minutes intra-service time) and CPT code 35650 *Bypass graft, with other than vein; axillary-axillary* (work RVU = 20.16 and 110 minutes intra-service time) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that the physician work and time is greater for CPT 23472, thus appropriately valued higher.
The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning, 15 minutes scrub/dress/wait time, 100 minutes intra-service time, 20 minutes immediate post-service time. The RUC indicated that the intra-service time of 100 minutes is confirmed by the RUC survey of 206 physician performing this service as well as the three studies sited above, from three large institutions and over 20,000 total hip/knee arthroplasties.

The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits (2) 99232, one discharge day (1) 99238, and three office visits (3) 99213 were appropriate. The RUC noted that one of the currently bundled hospital visits (1) 99231 is no longer typical. The RUC noted that the typical length of stay, thus hospital visits, have decreased from four visits prior to 2013 to two visits now in 2019 due to the pre-operative identification and optimization of medical co-morbidities work not explicitly captured in the standard survey or pre-service time. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. A second hospital visit occurs on post-operative day 1 and the patient is typically discharged on post-operative day 2. **The RUC recommends a work RVU of 19.60 for CPT code 27130.**

27447 ***Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)***
The RUC reviewed the survey results from 206 orthopaedic and hip/knee surgeons and determined a work RVU of 19.60 appropriately accounts for the work required to perform 27447. The RUC developed this recommendation by crosswalking 27447 to the work of 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time, 355 minutes of total time). These two services require similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform and therefore should be valued the same. For further support, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU = 19.44 and 100 minutes intra-service time), 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35 and 90 minutes intra-service time) and CPT code 35650 *Bypass graft, with other than vein; axillary-axillary* (work RVU = 20.16 and 110 minutes intra-service time) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that the physician work and time is greater for CPT 23472, thus appropriately valued higher.

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The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning, 15 minutes scrub/dress/wait time, 97 minutes intra-service time, 20 minutes immediate post-service time. The RUC indicated that the intra-service time of 97 minutes is confirmed by the RUC survey of 206 physician performing this service as well as the three studies sited above, from three large institutions and over 20,000 total hip/knee arthroplasties.

The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits (2) 99232, one discharge day (1) 99238, and three office visits (3) 99213 were appropriate. The RUC noted that one of the currently bundled hospital visits (1) 99231 is no longer typical. The RUC noted that the typical length of stay, thus hospital visits, have decreased from four visits prior to 2013 to two visits now in 2019 due to the pre-operative identification and optimization of medical co-morbidities work not explicitly captured in the standard survey or pre-service time. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. A second hospital visit occurs on post-operative day 1 and the patient is typically discharged on post-operative day 2. **The RUC recommends a work RVU of 19.60 for CPT code 27447.**

Practice Expense
The Practice Expense Subcommittee thoroughly discussed the clinical staff time for pre-service pre-operative planning activities. The survey respondents indicated, and the specialty societies recommended the median of 90 minutes to provide these services. The PE Subcommittee accepted the compelling evidence that the clinical work involved in the services had changed. Based on acceptance of compelling evidence. The PE Subcommittee entertained accepting the specialty society recommendation of an additional 30 minutes or an alternative of 15 minutes for these activities. The PE Subcommittee noted that the standard pre-service time package is 60 minutes for 090-day global period services, which was the survey 25th percentile. The PE Subcommittee entertained accepting the specialty society recommendation of an additional 30 minutes or an alternative of 15 minutes for these activities. The Subcommittee questioned who is performing the pre-operative planning work and at what setting: the orthopaedic practice, the consulting physician's practice or hospital employees. The PE Subcommittee noted that adding additional clinical staff time for these services would create an anomaly and provide discrepancies with other 090-day global services. Ultimately, the PE Subcommittee did not accept additional clinical staff time for these pre-service activities. The RUC also discussed capturing this additional clinical staff time and agreed with the PE Subcommittee not to capture any additional pre-operative planning time for clinical staff. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee**.

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

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CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	090	19.60
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	090	19.60

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27130 Tracking Number Original Specialty Recommended RVU: **20.72**
Presented Recommended RVU: **20.72**
Global Period: 090 Current Work RVU: **20.72** RUC Recommended RVU: **19.60**

CPT Descriptor: Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female has hip osteoarthritis not responding to non-operative treatment. A total hip arthroplasty (THA) is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Description of Pre-Service Work: On the day before and/or the day of surgery, the surgeon and/or qualified health care provider will complete the following work: Interview and examine the patient to confirm that the medical status and physical findings have not changed; update and sign the H&P; review the planned procedure and postoperative management with the patient and family; confirm or update the consent; sign or mark the operative site; re-review results of preadmission testing, including laboratory studies, X-rays and/or CT scans, with special attention to radiographs that were used for sizing and ordering of special implants or allografts; confirm timing and administration of antibiotics; assure appropriate selection, timing, and administration of DVT prophylaxis; verify all required instruments and supplies are available, including intraoperative fluoroscopy and cell saver; confirm all potential implants are available for possible use in the OR; prior to the induction of anesthesia, complete a comprehensive timeout and checklist review with the surgical team; place Foley catheter when indicated and/or requested by anesthesia; assist with positioning patient (lateral decubitus or supine traction table); pad bony prominences and apply thermal regulation drapes; prep and drape; mark surgical incision; and perform a second brief time out with the surgical team.

Description of Intra-Service Work: After incising the skin and the fascia, dissection is completed for exposure of the femur and acetabulum. The limb length is assessed by placing markers in the pelvis and the femur. A capsulotomy is performed and the femoral head is dislocated. A femoral neck osteotomy at the proper height is performed. The femoral canal is opened and reamed and then sequential rasping is performed with the broach/trial femoral component until correct rotational and axial stability is achieved. A calcar planer is used on the femoral neck osteotomy, when indicated, to fashion the bone. Additional dissection and releases are performed as needed to expose the acetabulum. Appropriate retractors are placed anteriorly as well as posteriorly. All excess capsule and redundant labrum is removed. All osteophytes are removed. The base of the acetabulum identified by utilizing a small reamer. Once the reamer is placed down to the medial wall of the acetabulum, sequential reamers are used in 1-2 mm increments up to the correct size based on the axial and off-center loading of the reamers. Trial acetabular implants are inserted and the hip is reduced. The stability of the leg is checked. The length of the leg is measured and the implants are adjusted as necessary. Once the proper implant sizing and joint stability are confirmed, the final femoral and acetabular components are inserted. The hip joint is reduced. A final check is made for stability, limb length, ROM and impingement. Sponge and needle counts are confirmed. The wound is copiously irrigated with saline and/or other solutions. The wound is closed in multiple layers, being careful to reattach the muscles to the proper structures.

Description of Post-Service Work: Immediate postoperative work through discharge from recovery room includes: application of sterile dressings; removal of drapes; waiting for reversal of anesthesia and extubation; assisting in transfer of the patient from the OR table to a stretcher or bed; assessing limb length and rotational alignment; assisting in transport of patient from operating room to recovery room; monitoring patient stabilization in the recovery room; completing a careful neurologic and vascular examination of the extremity; discussing postoperative recovery care with anesthesia and nursing staff, including regional blocks and/or patient controlled analgesia; discussing procedure and outcome with patient and family and answering questions; entering a brief operative note and a full operative report in the medical record; calling referring physician and/or sending a copy of the operative note; writing comprehensive orders for PACU and floor care; completing medication reconciliation; ordering and reviewing postoperative radiographs; and entering procedure data, including implant details, into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

Hospital visit #1 (day of surgery later in the day) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing vital signs, I/O, labs, and other related data; reviewing findings and outcome with patient and/or family; assessing pain control and response to current medications; modify orders accordingly; assessing urinary function; examining the surgical site; reinforce dressing as needed; assessing limb length, position and alignment; checking neurovascular status; assessing function of drains; repositioning the limb and/or immobilization devices as needed; counseling the patient and/or family regarding therapy protocol; answer questions; counseling the patient and/or family regarding OOB/ambulation, incentive spirometry, upright position in bed, and use of sequential compressive devices; reviewing postoperative radiographs; communicating and coordinating care with medical consult and other physicians; communicating and coordinating pain control with anesthesia, including status of current modalities (eg, blocks, catheters); updating orders; and writing “postoperative check” progress note.

Hospital visit #2 (postoperative day 1) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing PT/OT notes; discussing status and progress with PT/OT staff; reviewing discharge plan notes; discussing status and progress with case management; coordinating discharge plans; reviewing notes from other physicians; discussing status as appropriate; reviewing vital signs, I/O, labs and other related data; interviewing patient and obtaining interval history; assessing pain control and response to current medications; assessing gastrointestinal and urinary function; examining surgical site; change or reinforce dressing as needed; assessing limb alignment, position and ROM; checking neurovascular status; repositioning limb and/or immobilization devices as needed; assessing function of drain and remove as indicated; counseling patient and/or family regarding therapy protocol and answering questions;; counselling patient and/or family regarding OOB/ambulation, incentive spirometry, upright position in bed, and use of sequential compressive devices; discussing discharge plans with patient and/or family as well as case manager and nursing staff; communicating and coordinating care with other physicians (eg, medical consult, anesthesia/pain, critical care); writing daily progress notes; and updating orders.

Hospital discharge management (postoperative day #2) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing PT/OT notes; discussing status and progress with PT/OT staff; reviewing discharge plan notes; discussing status and progress with case management; finalizing and confirming discharge plans; reviewing notes from other physicians and discussing as appropriate; reviewing vital signs, I/O, labs and other related data; interviewing patient and obtaining interval history; assessing pain control and response to current medications; assessing gastrointestinal and urinary function; examining surgical site; changing dressing as needed; assessing limb alignment and ROM; checking neurovascular status; repositioning limb and/or immobilization devices as needed; finalizing and confirming discharge plans with patient and/or family; counselling patient and/or family regarding therapy protocol and activity limitations after discharge; reviewing postoperative instructions (eg, wound care, pain medications, VTE prophylaxis); completing daily progress note; completing discharge summary and associated forms and documents; writing prescriptions for medications and devices (eg, walker, wheelchair, bedside commode, raised toilet seat); checking narcotic prescription registries; writing orders for discharge to an inpatient rehabilitation facility, a skilled nursing facility, or home.; completing medication reconciliation; coordinate postoperative appointment with patient and/or family and office staff; communicating and coordinating follow-up care with other physicians; and entering postoperative data into longitudinal outcome databases or registries (eg, NSQIP, AJRR).

Office visit #1: Review PT/OT and/or rehab/SNF notes; review results of labs (eg, INR, Hb, Plts); interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; remove/change dressing; examine surgical site; remove sutures or staples; apply steri-strips; assess limb length, alignment, swelling, strength and ROM; check neurovascular status; review postoperative radiographs with patient and/or family; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding dental procedures and other invasive procedures (eg,

colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, out of work and other related forms; communicate and coordinate care with other physicians (eg, PCP, rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry)

Office visit #2: Review PT/OT and/or rehab/SNF notes; interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; examine surgical site; assess limb length, alignment swelling, strength and ROM; check neurovascular status; order and review postoperative radiographs with patient and/or family; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding return to driving; complete temporary handicap parking forms; counsel patient and/or family regarding dental procedures and other invasive procedures (eg, colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, back-to-work and other related forms; communicate and coordinate care with other physicians (eg, PCP, rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

Office visits #3: Review PT/OT and/or rehab/SNF notes; interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; examine surgical site; assess limb length, alignment swelling, strength and ROM; check neurovascular status; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding dental procedures and other invasive procedures (eg, colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, back-to-work and other related forms; communicate and coordinate care with other physicians (eg, PCP, Rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2019					
Presenter(s):	William Creevy, MD, AAOS RUC Advisor; Hussein Elkousy, MD, AAOS RUC Alternate Advisor; Adolph Yates, MD, AAHKS					
Specialty Society(ies):	American Academy of Orthopaedic Surgery (AAOS); American Association of Hip and Knee Surgeons (AAHKS)					
CPT Code:	27130					
Sample Size:	2650	**Resp N:**	206	**Response:** 7.7 %		
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	34.00	**80.00**	150.00	500.00
Survey RVW:	18.50	22.50	**24.00**	25.00	40.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	85.00	**100.00**	120.00	250.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	27130	**Recommended Physician Work RVU: 19.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**100.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23472	090	22.13	**RUC Time**

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22551	090	25.00	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	8,490

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33533	090	33.75	**RUC Time**	60,369

CPT Descriptor 2 Coronary artery bypass, using arterial graft(s); single arterial graft

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 103 **% of respondents:** 50.0 **%**

Number of respondents who choose 2nd Key Reference Code: 36 **% of respondents:** 17.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 27130	Top Key Reference CPT Code: 23472	2nd Key Reference CPT Code: **22551**
Median Pre-Service Time	70.00	75.00	98.00
Median Intra-Service Time	100.00	140.00	120.00
Median Immediate Post-service Time	20.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	80.0	80.00	40.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	69.0	85.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**377.00**	**448.00**	**395.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	32%	54%	10%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	53%	41%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	50%	42%
Physical effort required	1%	25%	74%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	52%	46%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	41%	39%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	47%	47%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	47%	53%
Physical effort required	0%	19%	81%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	64%	31%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

BACKGROUND

A public nomination was submitted to CMS in February 2018 indicating seven CPT codes as potentially misvalued, including total hip arthroplasty (27130). This nomination was made by Anthem, Inc., the largest for-profit managed care health insurance company in the Blue Cross and Blue Shield Association. Anthem administers Medicare, Medicaid and commercial health insurance plans.

Prior to publication of the CY 2019 MPFS final rule, at the October 2018 RUC meeting, the RAW noted that "this is a process issue and without more information on how these services were identified and rationale to review these services, the Workgroup will wait until the final rule for more information to determine whether to review these services." In the final rule, CMS stated there is value in consistent and routine review of high-volume services, because a minor adjustment to a high volume code may have a significant financial impact. RUC then placed the codes identified by Anthem on an LOI to survey for the April 2019 RUC meeting.

At the April 2019 RUC meeting, the American Academy of Orthopaedic Surgeons (AAOS) and the American Association of Hip and Knee Surgeons (AAHKS) recommended that the RUC reaffirm the current value of 20.72 for code 27130 and also reaffirm the current time and visits. The RUC voted against this proposal and requested that AAOS and AAHKS conduct a standard RUC survey and present a recommendation at the October 2019 RUC meeting.

June 2019 Request to Research Subcommittee for a Revised Survey Instrument

During preparation for the survey, the AAOS and AAHKS determined that the current standard 90-day global survey instrument does not adequately capture the extent of work performed by surgeons and other qualified health care providers (QHPs) in the pre- and postoperative period for the hip and knee total joint arthroplasty codes (27130, 27447). The societies also provided a compelling argument that there was significant clinical staff preoperative work related to patient optimization. A request was submitted for a revised survey instrument for discussion during the June 4, 2019 Research Subcommittee conference call. Several peer reviewed articles and extensive information on time required for pre- and postoperative work by physicians/QHPs and clinical staff were provided to support this request.

The Research Subcommittee agreed to add a question about clinical staff preoperative time, but did not agree to add questions about preoperative time for planning and optimization and postoperative work independent of hospital and office face-to-face visits. The rationale provided by the subcommittee was that the additional questions requested are not used for other codes with a 90-day global period. However, the Research Subcommittee noted that the specialties can recommend additional time beyond the pre-service package times if they believe it is supported by the literature, the survey, and is typical.

Subsequent to the June 2019 Research Subcommittee, AAOS and AAHKS finalized the approved survey instrument and conducted a random survey of AAOS and AAHKS members.

A total of 2,650 survey requests were sent out and 206 non-conflicted responses were received.

RECOMMENDATIONS

Work RVU

The current work RVU of 20.72 is recommended. This is below the survey median of 24.00 and below the survey 25th percentile of 22.50.

Pre-service time

Pre-time package 4 is selected: difficult patient / difficult procedure.

Evaluation time: We recommend adding 30 minutes to the standard package time of 40 minutes (total of 70 minutes) to account for significant additional preoperative time to optimize a patient prior to total joint replacement surgery.

Total hip arthroplasty is increasingly part of a mandatory Medicare bundled payment program (Comprehensive Care for Joint Replacement [CJR]) or an optional Medicare bundled payment program (Bundled Payment for Care Initiative [BPCI]). Similar alternative payment models are employed in many states by both Medicaid and private insurers. Physicians are also more commonly participating in accountable care organization programs with Medicare, Medicaid and private insurers. In all of these programs, physicians and hospitals have financial incentives to reduce costs and improve quality.

Preoperative identification and optimization of medical co-morbidities has been shown to shorten hospital length of stay and reduce complications, including readmissions. In a 2019 New England Journal of Medicine (NEJM) study on the outcomes of patients in the CJR program, the mean number of chronic medical conditions was seven. Considerable work by the surgeon and QHPs is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. Patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

All of this work is not explicitly captured in the standard RUC survey, nor is it included in the current RUC pre-time packages, but the work is certainly being performed on a routine basis for the typical patient. The specific tasks are noted above in the description of the pre-service work.

Positioning: Twelve minutes have been added to the standard package time of 3 minutes (total of 15 minutes) to account for positioning the patient lateral decubitus or supine on a traction top table. This is consistent with both the survey median and historical RUC precedent for many similar orthopaedic codes.

Scrub, dress and wait: Five minutes have been subtracted from the standard package of 20 minutes (total time of 15 minutes) to be consistent with the survey median.

Immediate Post-Service Time

Immediate post-time package 9b is selected: general anesthesia or complex regional block / complex procedure. Thirteen minutes have been subtracted to be consistent with the survey median.

Hospital Visits

We recommend 99232 x 2 and 99238 x 1 which is consistent with the survey median. This is a decrease of one hospital visit compared to the 2013 data which is the result of the considerable pre-service time expended on optimizing the patient for total joint replacement surgery. The first hospital visit occurs later on the same day as surgery; 83% of respondents reported that they completed this E/M encounter. The second hospital visit occurs on postoperative day #1. The specific tasks for both visits are detailed in the section for the description of the post-service work and support a level 99232 for both encounters. The patient is typically discharged on postoperative day #2 which is indicated by the discharge day code 99238. Patients may be seen more than once on these days (eg, morning and afternoon) to coordinate care and facilitate discharge.

Office Visits

We recommend 99213 x 3 which is consistent with the survey median.

SUMMARY

The transition to value-based alternative payment models has facilitated care delivery redesign for total hip arthroplasty, resulting in a shorter hospital length of stay, diminished utilization of post-acute care facilities, lower rates of hospital readmissions and reduced costs. A key change in this evolution is an increasing emphasis on preoperative optimization of patients prior to surgery with a corresponding shift in resource utilization to the pre-service period.

AAOS and AAHKS recommend the current work RVU of 20.72, which is below the survey 25th percentile; this is well supported by the survey results from a representative and robust survey with 206 respondents.

Key Reference Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMMED POST	POST-OP HOSITAL VISITS	POST-OP OFFICE VISITS
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	**19.60**	0.108	**377**	70	**100**	20	2-99232 1-99238	3-99213
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	**22.13**	0.089	**448**	75	**140**	30	1-99232 2-99231 1-99238	3-99213 1-99212
22851	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	**25.00**	0.140	**395**	98	**120**	30	1-99232 1-99238	3-99213

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMMED POST	POST-OP HOSITAL VISITS	POST-OP OFFICE VISITS
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	**17.75**	0.106	337	80	**103**	30	1-99232 1-99238	2-99213
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	**19.60**	0.108	377	70	**100**	20	2-99232 1-99238	3-99213
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	**33.75**	0.096	682	95	**158**	40	1-99291 3-99233 1-99232 1-99231 1-99238	1-99214 1-99212

ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK

1. Early Results of Medicare's Bundled Payment Initiative for a 90-Day Total Joint Arthroplasty Episode of Care, Iorio, Richard et al., The Journal of Arthroplasty, Volume 31, Issue 2, 343-350. *https://www.ncbi.nlm.nih.gov/pubmed/26427938*

2. Bundled Payments: Our Experience at an Academic Medical Center, Bolz, Nicholas J. et al., The Journal of Arthroplasty, Volume 31, Issue 5, 932-935 *https://www.ncbi.nlm.nih.gov/pubmed/27020651*

3. *Improvements in Total Joint Replacement Quality Metrics: Year one Versus Year Three of the Bundled Payments for Care Improvement Initiative, Dundon, John M. et al., The Journal of Bone & Joint Surgery, Volume 98, Issue 23, 1949-1953. https://www.ncbi.nlm.nih.gov/pubmed/27926675*

4. *Cost of Joint Replacement Using Bundled Payment Models, Navathe, Amol S. et al., JAMA Internal Medicine, Volume 177, Issue 2, 214-222. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2594805*

5. *Effect of Bundled Payments and Health Care Reform as Alternative Payment Models in Total Joint Arthroplasty: A Clinical Review, Siddiqi, Ahmed et al., The Journal of Arthroplasty, Volume 32, Issue 8, 2590 -2597. https://www.ncbi.nlm.nih.gov/pubmed/28438453*

6. Early Lessons on Bundled Payment at an Academic Medical Center, Jubelt, Lindsay E. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 25, Issue 9, 654-663. *https://www.ncbi.nlm.nih.gov/pubmed/28837458*

7. Total knee arthroplasty: improving outcomes with a multidisciplinary approach, Feng, James et al., Journal of Multidisciplinary Healthcare, Volume 2018, Issue 11, 63-73. *https://www.dovepress.com/total-knee-arthroplasty-improving-outcomes-with-a-multidisciplinary-ap-peer-reviewed-fulltext-article-JMDH*

8. Bundled Payment Arrangements: Key to Success, Bosco, Joseph A. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 26, Issue 23, 817-822. *https://www.ncbi.nlm.nih.gov/pubmed/30252787*

9. Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, Barnett, Michael L. et al., New England Journal of Medicine, Volume 380, Volume 6, 252-262. *https://www.nejm.org/doi/full/10.1056/NEJMsa1809010*

10. Risk stratification in primary total joint arthroplasty: the current state of knowledge, *Gronbeck, Christian et al., Arthroplasty Today, Volume 5, Issue 1, 126-131. https://www.arthroplastytoday.org/article/S2352-3441(18)30128-6/fulltext*

11. The Impact of Comprehensive Care for Joint Replacement Bundled Payment Program on Care Delivery, Sood, Neeraj et al., The Journal of Arthroplasty, Volume 34, Issue 4, 609-612. *https://www.arthroplastyjournal.org/article/S0883-5403(18)31162-8/fulltext*

12. Quantifying the Perioperative Work Associated with Total Hip and Knee Arthroplasty: The Burden Has Increased With Contemporary Care Pathways, Wasterlain, Amy S. et al., The Journal of Arthroplasty, Forthcoming 2019. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30630-8/fulltext*

13. Perioperative Telephone Encounters Should Be Included in the Relative Value Scale Update Committee Review of Time Spent on Total Hip and Knee Arthroplasty, Kheir, Matthew et al., The Journal of Arthroplasty, Volume 34, Issue 8, 1563-1569. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30467-X/abstract*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27130

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. nationale data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 162,006 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018 RUC database

Specialty orthopaedic surgery Frequency 162000 Percentage 99.99 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Orthopedic - Hip replacement

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 27130

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27447 Tracking Number Original Specialty Recommended RVU: **20.72**
Presented Recommended RVU: **19.60**
Global Period: 090 Current Work RVU: **20.72** RUC Recommended RVU: **19.60**

CPT Descriptor: Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old female has knee osteoarthritis not responding to non-operative treatment. A total knee arthroplasty (TKA) is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 13% , Overnight stay-more than 24 hours 87%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Description of Pre-Service Work:

On the day before and/or the day of surgery, the surgeon and/or qualified health care provider will complete the following work: Interview and examine the patient to confirm that the medical status and physical findings have not changed; update and sign the H&P; review the planned procedure and postoperative management with the patient and family; confirm or update the consent; sign or mark the operative site; re-review results of preadmission testing, including laboratory studies, X-rays and/or CT scans, with special attention to radiographs that were used for sizing and ordering of special implants or allografts; confirm timing and administration of antibiotics; assure appropriate selection, timing, and administration of DVT prophylaxis; verify all required instruments and supplies are available, including intraoperative fluoroscopy and cell saver; confirm all potential implants are available for possible use in the OR; prior to the induction of anesthesia, complete a comprehensive timeout and checklist review with the surgical team; place Foley catheter when indicated and/or requested by anesthesia; assist with positioning patient, pad bony prominences, and apply thermal regulation drapes; assess position of the extremities and head and adjust as needed; place patient's leg properly on the table and position with proper bolstering to aid surgical exposure; place a tourniquet on the proximal thigh; prep and drape; mark surgical incision; and perform a second brief time out with the surgical team.

Description of Intra-Service Work: After the tourniquet is elevated and following exsanguination, an acceptable surgical incision is utilized to expose the joint. After everting or subluxating the patella, appropriate soft tissue elevation and removal is performed to expose and visualize the joint. Care and attention are utilized to evaluate the ligament balance of the knee. Final ligament balancing usually occurs after the bony cuts are performed. The remnant meniscal tissue and overlying osteophytes are removed and if indicated, the cruciate ligaments are released. The patella is measured and then the articular surface is resected at the appropriate depth. The optimal component size is selected and the fixation holes drilled. The femur intramedullary canal is drilled and the distal femoral cutting block is applied. The alignment of the block is confirmed and the distal femoral resection is made. The AP and ML size of the distal femur is evaluated and the appropriate implant size selected following which the remaining chamfer and AP bone cuts of the distal femur are made. The tibia is subluxated forward and the tibial cutting guide is applied, the optimal position in all planes confirmed and the bone cut made. The tibia is sized for the appropriate implant and the bone prepared. The trial components are inserted and a trial reduction of the prosthetic knee is performed. Overall limb alignment, soft tissue and ligamentous balance and prosthetic interactions are assessed. Further refinement of the soft tissue balance, the bone resections for alignment and the

prosthetic implant interaction are performed as indicated to optimize the prosthetic longevity. Trials are then removed. The bony surfaces are cleaned with pulsatile lavage. The final implants are cemented into place. Trial tibial inserts are placed to confirm appropriate sizing. The final polyethylene insert is then placed onto the tibial prosthesis. Knee stability, range of motion and alignment are again confirmed. The tourniquet is released, hemostasis obtained, a deep drain placed and the wound closed in layers.

Description of Post-Service Work:
Immediate postoperative work through discharge from recovery room includes: application of sterile dressings; removal of drapes; waiting for reversal of anesthesia and extubation; assisting in transfer of the patient from the OR table to a stretcher or bed; assessing limb length and rotational alignment; assisting in transport of patient from operating room to recovery room; monitoring patient stabilization in the recovery room; completing a careful neurologic and vascular examination of the extremity; discussing postoperative recovery care with anesthesia and nursing staff, including regional blocks and/or patient controlled analgesia; discussing procedure and outcome with patient and family and answering questions; entering a brief operative note and a full operative report in the medical record; calling referring physician and/or sending a copy of the operative note; writing comprehensive orders for PACU and floor care; completing medication reconciliation; ordering and reviewing postoperative radiographs; and entering procedure data, including implant details, into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

Hospital visit #1 (day of surgery later in the day) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing vital signs, I/O, labs, and other related data; reviewing findings and outcome with patient and/or family; assessing pain control and response to current medications; modify orders accordingly; assessing urinary function; examining the surgical site; reinforce dressing as needed; assessing limb length, position and alignment; checking neurovascular status; assessing function of drains; repositioning the limb and/or immobilization devices as needed; counseling the patient and/or family regarding therapy protocol; answer questions; counseling the patient and/or family regarding OOB/ambulation, incentive spirometry, upright position in bed, and use of sequential compressive devices; reviewing postoperative radiographs; communicating and coordinating care with medical consult and other physicians; communicating and coordinating pain control with anesthesia, including status of current modalities (eg, blocks, catheters); updating orders; and writing “postoperative check” progress note.

Hospital visit #2 (postoperative day 1) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing PT/OT notes; discussing status and progress with PT/OT staff; reviewing discharge plan notes; discussing status and progress with case management; coordinating discharge plans; reviewing notes from other physicians; discussing status as appropriate; reviewing vital signs, I/O, labs and other related data; interviewing patient and obtaining interval history; assessing pain control and response to current medications; assessing gastrointestinal and urinary function; examining surgical site; change or reinforce dressing as needed; assessing limb alignment, position and ROM; checking neurovascular status; repositioning limb and/or immobilization devices as needed; assessing function of drain and remove as indicated; counseling patient and/or family regarding therapy protocol and answering questions;; counselling patient and/or family regarding OOB/ambulation, incentive spirometry, upright position in bed, and use of sequential compressive devices; discussing discharge plans with patient and/or family as well as case manager and nursing staff; communicating and coordinating care with other physicians (eg, medical consult, anesthesia/pain, critical care); writing daily progress notes; and updating orders.

Hospital discharge management (postoperative day #2) includes the following work: Reviewing nursing notes; discussing status and progress with nursing staff; reviewing PT/OT notes; discussing status and progress with PT/OT staff; reviewing discharge plan notes; discussing status and progress with case management; finalizing and confirming discharge plans; reviewing notes from other physicians and discussing as appropriate; reviewing vital signs, I/O, labs and other related data; interviewing patient and obtaining interval history; assessing pain control and response to current medications; assessing gastrointestinal and urinary function; examining surgical site; changing dressing as needed; assessing limb alignment and ROM; checking neurovascular status; repositioning limb and/or immobilization devices as needed; finalizing and confirming discharge plans with patient and/or family; counselling patient and/or family regarding therapy protocol and activity limitations after discharge; reviewing postoperative instructions (eg, wound care, pain medications, VTE prophylaxis); completing daily progress note; completing discharge summary and associated forms and documents; writing prescriptions for medications and devices (eg, walker, wheelchair, bedside commode, raised toilet seat); checking narcotic prescription registries; writing orders for discharge to an inpatient rehabilitation facility, a skilled nursing facility, or home.; completing medication reconciliation; coordinate postoperative appointment with patient and/or family and office staff; communicating and coordinating follow-up care with other physicians; and entering postoperative data into longitudinal outcome databases or registries (eg, NSQIP, AJRR).

Office visit #1: Review PT/OT and/or rehab/SNF notes; review results of labs (eg, INR, Hb, Plts); interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; remove/change dressing; examine surgical site; remove sutures or staples; apply steri-strips; assess limb length, alignment, swelling, strength and ROM; check neurovascular status; review postoperative radiographs with patient and/or family; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding dental procedures and other invasive procedures (eg, colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, out of work and other related forms; communicate and coordinate care with other physicians (eg, PCP, rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry)

Office visit #2: Review PT/OT and/or rehab/SNF notes; interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; examine surgical site; assess limb length, alignment swelling, strength and ROM; check neurovascular status; order and review postoperative radiographs with patient and/or family; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding return to driving; complete temporary handicap parking forms; counsel patient and/or family regarding dental procedures and other invasive procedures (eg, colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, back-to-work and other related forms; communicate and coordinate care with other physicians (eg, PCP, rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

Office visits #3: Review PT/OT and/or rehab/SNF notes; interview patient and obtain interval history; assess pain control and response to current medications; assess function, mobility and progress with PT/OT; assess gastrointestinal and urinary function; examine surgical site; assess limb length, alignment swelling, strength and ROM; check neurovascular status; counsel patient and/or family regarding wound care, therapy protocol and activity limitations; counsel patient and/or family regarding dental procedures and other invasive procedures (eg, colonoscopy); counsel patient and/or family regarding medications for DVT prophylaxis; counsel patient and/or family regarding next office visit; write or dictate and sign progress note; complete prescriptions for medications (eg, narcotics, NSAIDs, VTE prophylaxis); check narcotic prescription registries; complete forms for home care services (eg, VNA); complete PT/OT forms, referrals, or prescriptions; complete disability, back-to-work and other related forms; communicate and coordinate care with other physicians (eg, PCP, Rheumatology); and enter postoperative data into longitudinal outcome registries (eg, NSQIP, AJRR, and/or local registry).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2019				
Presenter(s):	William Creevy, MD, AAOS RUC Advisor; Hussein Elkousy, MD, AAOS RUC Alternate Advisor; Adolph Yates, MD, AAHKS				
Specialty Society(ies):	American Academy of Orthopaedic Surgery (AAOS); American Association of Hip and Knee Surgeons (AAHKS)				
CPT Code:	27447				
Sample Size:	2650	**Resp N:**	206	**Response:** 7.7 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	60.00	**100.00**	200.00	500.00
Survey RVW:	17.00	22.14	**24.00**	25.00	32.50
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	86.00	**97.00**	120.00	185.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	27447	**Recommended Physician Work RVU: 19.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**97.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23472	090	22.13	**RUC Time**

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22551	090	25.00	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	8,490

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33533	090	33.75	**RUC Time**	60,369

CPT Descriptor 2 Coronary artery bypass, using arterial graft(s); single arterial graft

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 90 **% of respondents:** 43.6 **%**

Number of respondents who choose 2nd Key Reference Code: 32 **% of respondents:** 15.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 27447	Top Key Reference CPT Code: 23472	2nd Key Reference CPT Code: **22551**
Median Pre-Service Time	70.00	75.00	98.00
Median Intra-Service Time	97.00	140.00	120.00
Median Immediate Post-service Time	20.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	80.0	80.00	40.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	69.0	85.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**374.00**	**448.00**	**395.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	34%	48%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	58%	38%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	47%	43%
Physical effort required	1%	36%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	55%	42%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	38%	50%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	56%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	44%	53%
Physical effort required	3%	28%	69%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	72%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

BACKGROUND

A public nomination was submitted to CMS in February 2018 indicating seven CPT codes as potentially misvalued, including total knee arthroplasty (27447). This nomination was made by Anthem, Inc., the largest for-profit managed care health insurance company in the Blue Cross and Blue Shield Association. Anthem administers Medicare, Medicaid and commercial health insurance plans.

Prior to publication of the CY 2019 MPFS final rule, at the October 2018 RUC meeting, the RAW noted that "this is a process issue and without more information on how these services were identified and rationale to review these services, the Workgroup will wait until the final rule for more information to determine whether to review these services." In the final rule, CMS stated there is value in consistent and routine review of high-volume services, because a minor adjustment to a high volume code may have a significant financial impact. RUC then placed the codes identified by Anthem on an LOI to survey for the April 2019 RUC meeting.

At the April 2019 RUC meeting, the American Academy of Orthopaedic Surgeons (AAOS) and the American Association of Hip and Knee Surgeons (AAHKS) recommended that the RUC reaffirm the current value of 20.72 and also reaffirm the current time and visits. The RUC voted against this proposal and requested that AAOS and AAHKS conduct a standard RUC survey and present a recommendation at the October 2019 RUC meeting.

June 2019 Request to Research Subcommittee for a Revised Survey Instrument

During preparation for the survey, the AAOS and AAHKS determined that the current standard 90-day global period survey instrument does not adequately capture the extent of work performed by physicians and qualified health care providers (QHPs) in the pre- and post-operative period for the hip and knee total joint arthroplasty codes (27130, 27447). The societies also provided a compelling argument that there was significant clinical staff pre-service work related to patient optimization. A request was submitted for a revised survey instrument for discussion during the June 4, 2019 Research Subcommittee conference call.

Several peer reviewed articles and extensive information on time required for pre- and post-operative work by physicians/QHPs and clinical staff were provided to support this recommendation. The Research Subcommittee agreed to add a question about clinical staff pre-service time but did not agree to add questions about pre-service time for planning and optimization and post-operative work independent of hospital and office face-to-face visits. The rationale was that the same questions are not used for other codes with a 90-day global period. However, the Research Subcommittee noted that the specialties can recommend additional time beyond the pre-service package times, if they believe it is supported by the literature, the survey, and is typical.

Subsequent to the June 2019 Research Subcommittee, AAOS and AAHKS finalized the approved survey instrument and conducted a random survey of AAOS and AAHKS members.

A total of 2,650 survey requests were sent out and 206 non-conflicted responses were received.

RECOMMENDATIONS

Work RVU:

The current work RVU of 20.72 is recommended. This is below the survey median of 24.00 and below the survey 25th percentile of 22.14.

Pre-service time:

Pre-time package 4 is selected: difficult patient / difficult procedure.

Evaluation time: We recommend adding 30 minutes to the standard package time of 40 minutes (total of 70 minutes) to account for significant additional pre-operative time to optimize a patient prior to total joint replacement surgery.

Total knee arthroplasty is increasingly part of a mandatory Medicare bundled payment program (Comprehensive Care for Joint Replacement [CJR]) or an optional Medicare bundled payment program (Bundled Payment for Care Initiative [BPCI]). Similar alternative payment models are employed in many states by both Medicaid and private insurers. Physicians are also more commonly participating in accountable care organization programs with Medicare, Medicaid and private insurers. In all of these programs, physicians and hospitals have financial incentives to reduce costs and improve quality.

Pre-operative identification and optimization of medical co-morbidities has been shown to shorten hospital length of stay and reduce complications, including readmissions. In a 2019 New England Journal of Medicine (NEJM) study on the outcomes of patients in the CJR program, the mean number of chronic medical conditions was seven. Considerable work by the surgeon and QHPs is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. Patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

All of this work is not explicitly captured in the standard RUC survey, nor is it included in the current RUC pre-time packages, but the work is certainly being performed on a routine basis for the typical patient. The specific tasks are noted above in the description of the pre-service work.

Positioning: Twelve minutes have been added to the standard package time of 3 minutes (total of 15 minutes) to account for positioning the patient supine; apply a tourniquet; confirm tourniquet settings and validate function. This is consistent with both the survey median and historical RUC precedent for many similar orthopaedic codes.

Scrub, dress and wait: Five minutes have been subtracted from the standard package of 20 minutes (total time of 15 minutes) to be consistent with the survey median.

Immediate Post-Service Time

Immediate post-time package 9b is selected: general anesthesia or complex regional block / complex procedure. Thirteen minutes have been subtracted to be consistent with the survey median.

Hospital Visits

We recommend 99232 x 2 and 99238 x 1 which is consistent with the survey median. This is a decrease of one hospital visit compared to the 2013 data which is the result of the considerable pre-service time expended on optimizing the patient for total joint replacement surgery. The first hospital visit occurs later on the same day as surgery; 83% of respondents reported that they completed this E/M encounter. The second hospital visits occurs on post-operative day #1. The specific tasks for both visits are detailed in the section for the description of the post-service work and support a level 99232 for both encounters. The patient is typically discharged on post-operative day #2 which is indicated by the discharge day code 99238. Patients may be seen more than once on these days (e.g. morning and afternoon) to coordinate care and facilitate discharge.

Office Visits

We recommend 99213 x 3 which is consistent with the survey median.

SUMMARY

The transition to value-based alternative payment models has facilitated care delivery redesign for total hip arthroplasty, resulting in a shorter hospital length of stay, diminished utilization of post-acute care facilities, lower rates of hospital readmissions and reduced costs. A key change in this evolution is an increasing emphasis on pre-operative optimization of patients prior to surgery with a corresponding shift in resource utilization to the pre-service period.

AAOS and AAHKS recommend the current work RVU of 20.72, which is below the survey 25th percentile; this is well supported by the survey results from a representative and robust survey with 206 respondents.

Key Reference Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMMED POST	POST-OP HOSITAL VISITS	POST-OP OFFICE VISITS
27447	Arthroplasty, knee, condyle and plateau medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	**19.60**	0.112	**374**	70	**97**	20	2-99232 1-99238	3-99213
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	**22.13**	0.089	**448**	75	**140**	30	1-99232 2-99231 1-99238	3-99213 1-99212
22851	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	**25.00**	0.140	**395**	98	**120**	30	1-99232 1-99238	3-99213

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMMED POST	POST-OP HOSITAL VISITS	POST-OP OFFICE VISITS
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	**17.75**	0.106	337	80	**103**	30	1-99232 1-99238	2-99213
27447	Arthroplasty, knee, condyle and plateau medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	**19.60**	0.112	**374**	70	**97**	20	2-99232 1-99238	3-99213
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	**33.75**	0.096	682	95	**158**	40	1-99291 3-99233 1-99232 1-99231 1-99238	1-99214 1-99212

ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK

1. Early Results of Medicare's Bundled Payment Initiative for a 90-Day Total Joint Arthroplasty Episode of Care, Iorio, Richard et al., The Journal of Arthroplasty, Volume 31, Issue 2, 343-350. *https://www.ncbi.nlm.nih.gov/pubmed/26427938*

2. Bundled Payments: Our Experience at an Academic Medical Center, Bolz, Nicholas J. et al., The Journal of Arthroplasty, Volume 31, Issue 5, 932-935 *https://www.ncbi.nlm.nih.gov/pubmed/27020651*

3. *Improvements in Total Joint Replacement Quality Metrics: Year one Versus Year Three of the Bundled Payments for Care Improvement Initiative, Dundon, John M. et al., The Journal of Bone & Joint Surgery, Volume 98, Issue 23, 1949-1953. https://www.ncbi.nlm.nih.gov/pubmed/27926675*

4. *Cost of Joint Replacement Using Bundled Payment Models, Navathe, Amol S. et al., JAMA Internal Medicine, Volume 177, Issue 2, 214-222. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2594805*

5. *Effect of Bundled Payments and Health Care Reform as Alternative Payment Models in Total Joint Arthroplasty: A Clinical Review, Siddiqi, Ahmed et al., The Journal of Arthroplasty, Volume 32, Issue 8, 2590 -2597. https://www.ncbi.nlm.nih.gov/pubmed/28438453*

6. Early Lessons on Bundled Payment at an Academic Medical Center, Jubelt, Lindsay E. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 25, Issue 9, 654-663. *https://www.ncbi.nlm.nih.gov/pubmed/28837458*

7. Total knee arthroplasty: improving outcomes with a multidisciplinary approach, Feng, James et al., Journal of Multidisciplinary Healthcare, Volume 2018, Issue 11, 63-73. *https://www.dovepress.com/total-knee-arthroplasty-improving-outcomes-with-a-multidisciplinary-ap-peer-reviewed-fulltext-article-JMDH*

8. Bundled Payment Arrangements: Key to Success, Bosco, Joseph A. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 26, Issue 23, 817-822. *https://www.ncbi.nlm.nih.gov/pubmed/30252787*

9. Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, Barnett, Michael L. et al., New England Journal of Medicine, Volume 380, Volume 6, 252-262. *https://www.nejm.org/doi/full/10.1056/NEJMsa1809010*

10. Risk stratification in primary total joint arthroplasty: the current state of knowledge, *Gronbeck, Christian et al., Arthroplasty Today, Volume 5, Issue 1, 126-131. https://www.arthroplastytoday.org/article/S2352-3441(18)30128-6/fulltext*

11. The Impact of Comprehensive Care for Joint Replacement Bundled Payment Program on Care Delivery, Sood, Neeraj et al., The Journal of Arthroplasty, Volume 34, Issue 4, 609-612. *https://www.arthroplastyjournal.org/article/S0883-5403(18)31162-8/fulltext*

12. Quantifying the Perioperative Work Associated with Total Hip and Knee Arthroplasty: The Burden Has Increased With Contemporary Care Pathways, Wasterlain, Amy S. et al., The Journal of Arthroplasty, Forthcoming 2019. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30630-8/fulltext*

13. Perioperative Telephone Encounters Should Be Included in the Relative Value Scale Update Committee Review of Time Spent on Total Hip and Knee Arthroplasty, Kheir, Matthew et al., The Journal of Arthroplasty, Volume 34, Issue 8, 1563-1569. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30467-X/abstract*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27447

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. nationale data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
306,305 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018 RUC database

Specialty orthopaedic surgery Frequency 306000 Percentage 99.90 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Orthopedic - Knee replacement

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 27447

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Hip/Knee Arthroplasty

TAB: 11

					RVW					Total	PRE			INTRA				POST				POST-OFFICE
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	15 14 13 12 11
REF1	23472	Arthroplasty, glenohumeral joint	103	0.089			22.13			448	40	15	20			140			30	1	2		1.0	3 1
REF2	22551	Arthrodesis, anterior interbody,	36	0.140			25.00			395	60	18	20			120			30	1			1.0	3
2013 RUC Rec	27130	'Arthroplasty, acetabular and pr	150	0.110			19.60			380	40	15	20			100			25	1	2		1.0	2 1
current	27130	Arthroplasty, acetabular and pro		0.110			20.72			407	40	15	20			100			25	2	1		1.0	3
SVY	27130	Arthroplasty, acetabular and pro	206	0.152	18.50	22.50	24.00	25.00	40.00	377	40	15	15	45	85	100	120	250	20	2			1.0	3
REC	27130	'Arthroplasty, acetabular and proxir		0.108			19.60			377	40	15	15			100			20	2			1.0	3

REF1	23472	Arthroplasty, glenohumeral joint	90	0.089			22.13			448	40	15	20			140			30	1	2		1.0	3 1
REF2	22551	Arthrodesis, anterior interbody,	32	0.140			25.00			395	60	18	20			120			30	1			1.0	3
2013 RUC Rec	27447	Arthroplasty, knee, condyle a	157	0.110			19.60			380	40	15	20			100			25	1	2		1.0	2 1
current	27447	Arthroplasty, knee, condyle and		0.110			20.72			407	40	15	20			100			25	2	1		1.0	3
SVY	27447	Arthroplasty, knee, condyle and	206	0.158	17.00	22.14	24.00	25.00	32.50	374	40	15	15	45	86	97	120	185	20	2			1.0	3
REC	27447	'Arthroplasty, acetabular and proxir		0.112			19.60			374	40	15	15			97			20	2			1.0	3

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CPT Code	Long Descriptor	Global Period
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	090
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
27130	A 72-year-old female has hip osteoarthritis not responding to non-operative treatment. A total hip arthroplasty (THA) is performed.
27447	A 74-year-old female has knee osteoarthritis not responding to non-operative treatment. A total knee arthroplasty (TKA) is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The specialty societies also submitted a request to the RUC Research Subcommittee to add an additional question to the standard RUC survey regarding pre-service clinical staff time. The Research Subcommittee approved the request and the following question was added to the survey:

Background for Question 7: Clinical Staff Time

The purpose of this question is to capture the clinical staff time provided by health care professionals who are paid by your practice and cannot bill separately, such as registered nurses (RNs), licensed practical nurses (LPNs), and certified medical assistants (MA), or other clinical staff employed in your practice. Do not count the clinical staff time for any separately reported services performed on the same date or other dates (eg, chronic care management services performed during the month).

Clinical staff activities DO NOT INCLUDE time for any administrative activities no matter who performs these services, including:

- Obtain referral documents
- Schedule patient/remind patient of appointment
- Obtain medical records/manage patient database/develop chart
- Pre-certify patient/conduct pre-service billing
- Verify insurance/register patient
- Transcribe results/file and manage patient records
- Schedule subsequent post service follow-up visits
- Conduct billing and collection activities

QUESTION 7: Pre-operative CLINICAL STAFF TIME: How much total time does your clinical staff (eg, RN, LPN, MA) spend per patient on the following planning, preparation, optimization and care coordination activities prior to surgery?

Please include the CLINICAL STAFF TIME for planning the case and preparation of the patient prior to the procedure, but separate and after the decision-for-surgery visit, which may include the following activities:

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- Schedule space and equipment in the operating room.
- Coordinate pre-operative services (including test results).
- Coordinate pre-operative assessment with anesthesia.
- Coordinate pre-operative services with physical therapy, case manager and/or social worker.
- Provide pre-operative education.
- Coordinate final clearance assessment.
- Complete pre-operative phone calls, e-mails, or other communications with patient, family and other providers to coordinate care and optimization.
- Complete pre-operative phone calls, e-mails, or other communications with patient or family to review preparation and instructions (eg, NPO, medications, antibiotic shower).

	27447	27130
TOTAL Pre-operative CLINICAL STAFF TIME (minutes)		

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

Current codes are used for reference.

3. Is this code(s) typically reported with an E/M service?

No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

The clinical staff time involved in providing total joint arthroplasty has changed considerably in the past six plus years since 27130 and 27447 were last surveyed (2012/2013). Since 2013 the use of pre-operative optimization protocols for Total Joint patients has become typical and involves a considerable change in work done by clinical staff prior to surgery.

These activities include

- Schedule space and equipment in OR.
- Coordinate pre-surgery services (including test results).
- Coordinate pre-operative assessment with anesthesia.
- Coordinate pre-operative services with physical therapy, case manager and/or social worker.
- Provide pre-operative education.
- Coordinate final clearance assessment.
- Complete pre-operative phone calls, e-mails, or other communications with patient, family and other providers to coordinate care and optimization.
- Complete pre-operative phone calls, e-mails, or other communications with patient or family to review preparation and instructions (eg, NPO, medications, antibiotic shower).

Previous surveys did not address this work, and we believe the additional work merited survey, which compelled the societies to request the additional question. We believe the survey results illustrate that indeed the clinical work is greater in the pre-service period than in previous years and is

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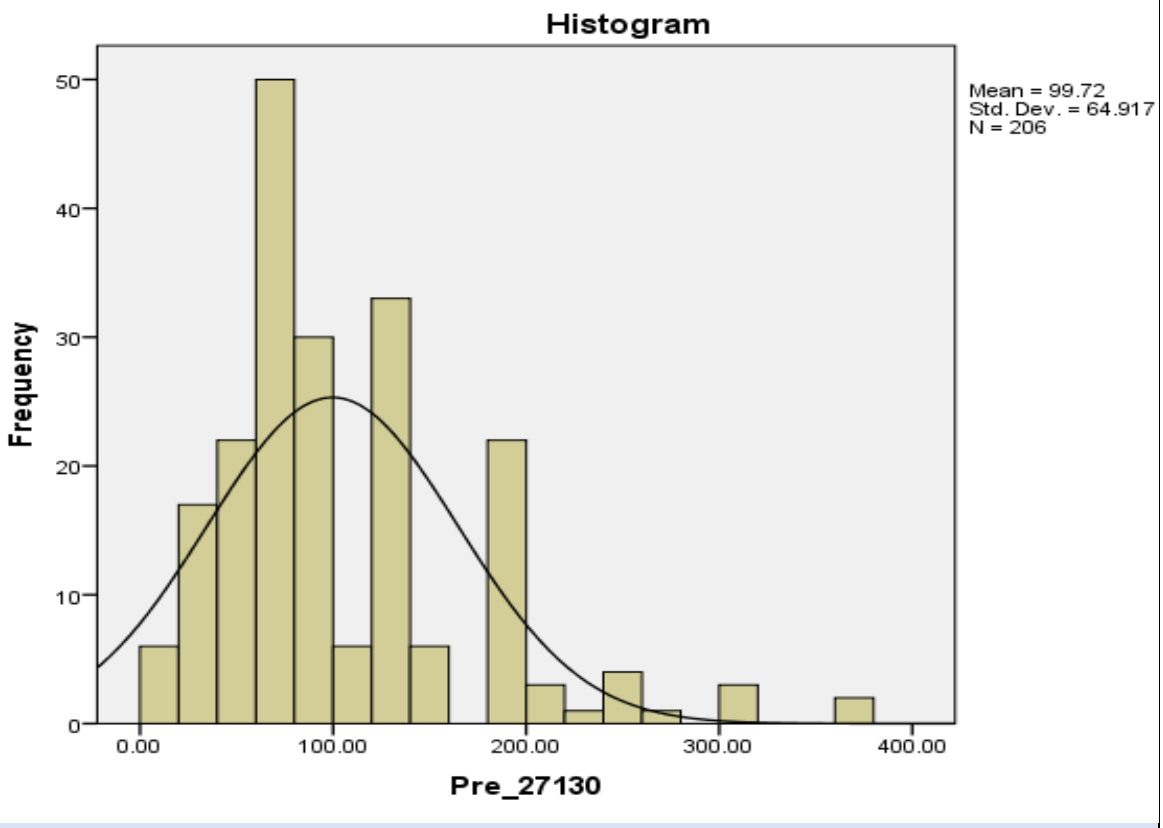
sufficiently different from the clinical standard. Please see the following literature on pre and post-service work done non face-to-face in Total Hip Arthroplasty and Total Knee Arthroplasty.

SUMMARY OF SURVEY RESPONDENTS TO CLINICAL STAFF QUESTION

Summary of Data for Question 7, Tab 11-Hip/Knee Arthroplasty in minutes

CPT	DESC	MIN	25TH %	MEDIAN	75TH%	MAX
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	0	60	90	120	360
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	0	60	90	120	360



AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
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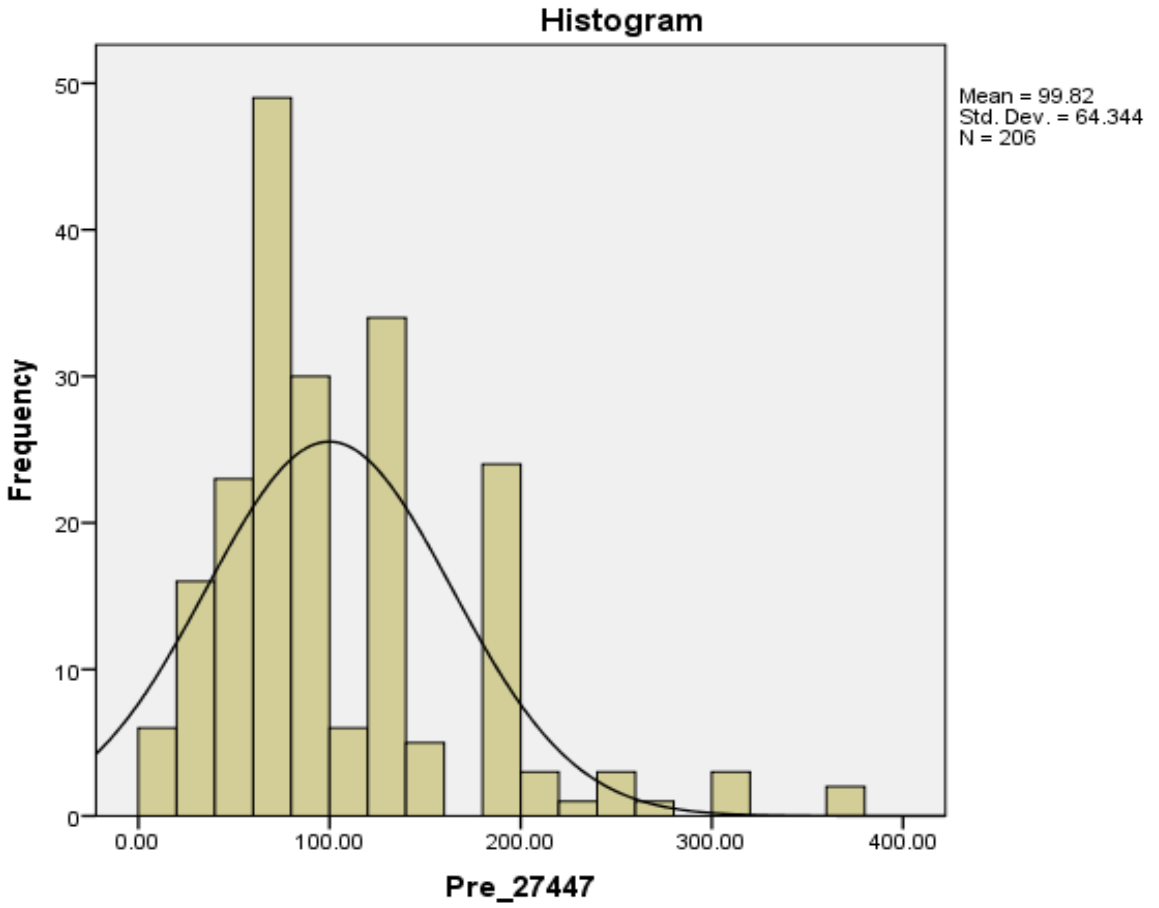

ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK

1. Early Results of Medicare's Bundled Payment Initiative for a 90-Day Total Joint Arthroplasty Episode of Care, Iorio, Richard et al., The Journal of Arthroplasty, Volume 31, Issue 2, 343-350. *https://www.ncbi.nlm.nih.gov/pubmed/26427938*
2. Bundled Payments: Our Experience at an Academic Medical Center, Bolz, Nicholas J. et al., The Journal of Arthroplasty, Volume 31, Issue 5, 932-935 *https://www.ncbi.nlm.nih.gov/pubmed/27020651*
3. *Improvements in Total Joint Replacement Quality Metrics: Year one Versus Year Three of the Bundled Payments for Care Improvement Initiative, Dundon, John M. et al., The Journal of Bone & Joint Surgery, Volume 98, Issue 23, 1949-1953. https://www.ncbi.nlm.nih.gov/pubmed/27926675*
4. *Cost of Joint Replacement Using Bundled Payment Models, Navathe, Amol S. et al., JAMA Internal Medicine, Volume 177, Issue 2, 214-222. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2594805*
5. *Effect of Bundled Payments and Health Care Reform as Alternative Payment Models in Total Joint Arthroplasty: A Clinical Review, Siddiqi, Ahmed et al., The Journal of Arthroplasty, Volume 32, Issue 8, 2590 -2597. https://www.ncbi.nlm.nih.gov/pubmed/28438453*

6. Early Lessons on Bundled Payment at an Academic Medical Center, Jubelt, Lindsay E. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 25, Issue 9, 654-663. *https://www.ncbi.nlm.nih.gov/pubmed/28837458*
7. Total knee arthroplasty: improving outcomes with a multidisciplinary approach, Feng, James et al., Journal of Multidisciplinary Healthcare, Volume 2018, Issue 11, 63-73. *https://www.dovepress.com/total-knee-arthroplasty-improving-outcomes-with-a-multidisciplinary-ap-peer-reviewed-fulltext-article-JMDH*
8. Bundled Payment Arrangements: Key to Success, Bosco, Joseph A. et al., Journal of the American Academy of Orthopaedic Surgery, Volume 26, Issue 23, 817-822. *https://www.ncbi.nlm.nih.gov/pubmed/30252787*
9. Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, Barnett, Michael L. et al., New England Journal of Medicine, Volume 380, Volume 6, 252-262. *https://www.nejm.org/doi/full/10.1056/NEJMsa1809010*
10. Risk stratification in primary total joint arthroplasty: the current state of knowledge, *Gronbeck, Christian et al., Arthroplasty Today, Volume 5, Issue 1, 126-131. https://www.arthroplastytoday.org/article/S2352-3441(18)30128-6/fulltext*
11. The Impact of Comprehensive Care for Joint Replacement Bundled Payment Program on Care Delivery, Sood, Neeraj et al., The Journal of Arthroplasty, Volume 34, Issue 4, 609-612. *https://www.arthroplastyjournal.org/article/S0883-5403(18)31162-8/fulltext*
12. Quantifying the Perioperative Work Associated with Total Hip and Knee Arthroplasty: The Burden Has Increased With Contemporary Care Pathways, Wasterlain, Amy S. et al., The Journal of Arthroplasty, Forthcoming 2019. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30630-8/fulltext*
13. Perioperative Telephone Encounters Should Be Included in the Relative Value Scale Update Committee Review of Time Spent on Total Hip and Knee Arthroplasty, Kheir, Matthew et al., The Journal of Arthroplasty, Volume 34, Issue 8, 1563-1569. *https://www.arthroplastyjournal.org/article/S0883-5403(19)30467-X/abstract*

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

See response to Question 4. Increase in aggregate cost is reflective of increase in pre-service patient optimization time.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

	Complete pre-service diagnostic and referral forms	**5 minutes (standard)**

	Staff reviews all forms with patient and/or caregiver to ensure all relevant history and diagnostic information is included
Coordinate pre-surgery services (including test results)	**30 minutes (20 min standard plus 10 add'l min)** Staff coordinates collection and documentation of test results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Staff coordinate requisite pre-surgery appointments and visits with physical therapy, psychology, and social worker/case worker. Staff receive records from requisite pre-operative visits and incorporate information into optimization protocols and records. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	**8 minutes (standard)** Staff interacts with facility to schedule space, supplies, equipment, and review checklists
Provide pre-service education/obtain consent	**40 minutes (20 min standard plus 20 add'l min)** Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions. Staff conduct in-person pre-surgery course for patients. Staff conduct a pre-clearance assessment and final clearance for surgery
Complete pre-procedure phone calls and prescription	**7 minutes (standard)** Staff reviews preoperative medication changes, reviews patient medical status, confirms preoperative cleansing protocol, and answers final pre-admission questions.

b. Service period (includes pre, intra and post):

12 minutes (standard)

Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as:

- Responding to patient/family questions about home activity restrictions/WB status, therapy questions
- Answer questions regarding dressing/wound management, showering/bathing, personal grooming
- Confirmation of home equipment
- Confirmation of discharge ABX if needed, pain medication, use of anticoagulation
- Coordination with PCP's office for transfer of records
- Telephonic or electronic communication assistance with the office, and other necessary management assistance related to the hospitalization.
- Transitioning discharge information to the office medical record, including correspondence and imaging or lab results pending at discharge

c. Post-service period:

108 minutes - standard time for <u>current</u> (2019) office visit E/Ms

Clinical staff will greet the patient, provide gowning, and ensure that all appropriate medical records are available including interval imaging and labs, physical therapy reports, and chart notes from other

physicians. Clinical staff will obtain vital signs, prepare the room and necessary supplies, assist with patient positioning for exam, review and document history, systems and medications. Clinical staff will assist the physician during the exam which may include wound and drain (if present) assessment, neurovascular assessment, ROM assessment, and staple removal when appropriate. Clinical staff will clean the room and answer any patient/family questions about home care including activity limitations and reinforcement of physical therapy activities. Clinical staff will assist the physician with orders for medication and physical therapy changes. Clinical staff will assist with answering patient, family, caregiver, therapist, other clinician questions and help process changes in care.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

14. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF031	table, power	Time is equal to office visit total time based on current (2019) database time.

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

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17. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**27130**		**27130**		**27447**		**27447**	
3		***RUC Collaboration Website***				Total Hip Arthroplasty, acetabular and proximal femoral		Total Hip Arthroplasty, acetabular and proximal femoral		Total Knee Arthroplasty, knee, condyle and plateau; medial AND lateral		Total Knee Arthroplasty, knee, condyle and plateau; medial AND lateral	
4	**Clinical Activity Code**	**Meeting Date: 10/2019 Tab: 11 Specialty: AAOS, AAHKS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**n/a**	**90**	**n/a**	**90**	**n/a**	**90**	**n/a**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 79.67**	**$ -**	**$ 79.67**	**$ -**	**$ 79.67**	**$ -**	**$ 79.67**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**180**	**0**	**180**	**0**	**180**	**0**	**180**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**60**	**0**	**60**	**0**	**60**	**0**	**60**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**12**	**0**	**12**	**0**	**12**	**0**	**12**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**108**	**0**	**108**	**0**	**108**	**0**	**108**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 66.60**	**$ -**	**$ 66.60**	**$ -**	**$ 66.60**	**$ -**	**$ 66.60**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery/procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20		20		20
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8		8		8
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7		7		7
26		**End: When patient enters office/facility for surgery/procedure**											
27		**SERVICE PERIOD**											
28		**Start: When patient enters office/facility for surgery/procedure:**											
71	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
78		**End: Patient leaves office/facility**											
79		**POST-SERVICE PERIOD**											
80		**Start: Patient leaves office/facility**											
83		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
84		99211 16 minutes	16										
85		99212 27 minutes	27										
86		99213 36 minutes	36				3		3		3		3
87		99214 53 minutes	53										
88		99215 63 minutes	63										
89	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**108.0**	**0.0**	**108.0**	**0.0**	**108.0**	**0.0**	**108.0**
96		**End: with last office visit before end of global period**											

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2						**27130**		**27130**		**27447**		**27447**	
3		***RUC Collaboration Website***				Total Hip		Total Hip		Total Knee		Total Knee	
4	**Clinical Activity Code**	**Meeting Date: 10/2019 Tab: 11 Specialty: AAOS, AAHKS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Arthroplasty, acetabular and proximal femoral		Arthroplasty, acetabular and proximal femoral		Arthroplasty, knee, condyle and plateau; medial AND lateral		Arthroplasty, knee, condyle and plateau; medial AND lateral	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**n/a**	**90**	**n/a**	**90**	**n/a**	**90**	**n/a**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 79.67**	**$ -**	**$ 79.67**	**$ -**	**$ 79.67**	**$ -**	**$ 79.67**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**180**	**0**	**180**	**0**	**180**	**0**	**180**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**60**	**0**	**60**	**0**	**60**	**0**	**60**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**12**	**0**	**12**	**0**	**12**	**0**	**12**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**108**	**0**	**108**	**0**	**108**	**0**	**108**
97	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
98		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 11.33**	**$ -**	**$ 11.33**	**$ -**	**$ 11.33**	**$ -**	**$ 11.33**
99	SA048	pack, minimum multi-specialty visit	2.1122	pack			3		3		3		3
100	SA052	pack, post-op incision care (staple)	4.992	pack			1		1		1		1
101													
103	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 1.75**	**$ -**	**$ 1.75**	**$ -**	**$ 1.75**	**$ -**	**$ 1.75**
105	EF031	table, power	6091.913	Office Visits	0.016166271		108		108		108		108
106													

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request – Final Rule for 2021

April 2021

Immunization Administration – Tab 19

After considering public comments to the Proposed Rule for the CY 2021 Medicare Physician Payment Schedule, CMS did not finalize the proposal to crosswalk the valuation of CPT codes 90460, 90471, 90473 and HCPCS codes G0008, G0009, and G0010 to CPT code 36000 *Introduction of needle or intracatheter, vein* (work RVU = 0.18). CMS instead finalized a policy to maintain the CY 2019 payment for nine of the services in the immunization administration family, including the add-on codes. Maintaining the CY 2019 rates for these services also maintained the historical relationship between the base administration codes and the add-on CPT codes 90461, 90472, and 90474, instead of the proposal to value the add-on codes at 50 percent of the base codes. As previously discussed in the Proposed Rule, CMS approximated a cost for these services, but acknowledged the concerns that were raised in the public rulemaking comments received and will continue to seek additional information that specifically reflects the resource costs and inputs that should be considered to establish payment for these services on a long-term basis. CMS welcomes the results of an updated formal review of these services as well as any additional information that may be helpful for valuation in the immediate future. Based on CMS' comments, the RUC reviewed these services at the April 2021 RUC meeting.

Compelling Evidence
The specialties provided compelling evidence that the current values for these services were derived via flawed methodology. The pediatric immunization administration codes, 90460 and 90461, were developed to promote physician counseling of hesitant parents and use of combination vaccines to address decline in national immunization rates and subsequently valued by the RUC in October 2009. However, in the 2011 Medicare Physician Payment Schedule, CMS did not accept the RUC recommendations for 90460 and 90461. Instead, CMS applied the same methodology used for the existing immunization administration codes (90471-90474) to establish the values for 90460 and 90461. CMS valued codes 90471 and 90473 (base) codes by hard coding them to code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* and then setting the RVUs for the add-on codes (90472 and 90474) at approximately half the value of the base codes. While the CMS values in and of themselves do not create flawed methodology, the process associated with valuing these codes is flawed for several reasons.

In contrast from how the RUC uses crosswalks to recommend a one-time value for a service for physician work, CMS hard-coded the physician work, PE and PLI RVUs for 90460 to 96372. As a result, when PE inputs for code 96372 were subsequently reduced by the RUC in January 2017, CMS automatically reduced the PE values for 90460 even though the same reductions in clinical staff time did not pertain to 90460. These reductions threatened the US national vaccination program by reducing the value below the Medicaid minimum payment rate for immunization administration. The specialties then began working with CMS to identify an alternative crosswalk methodology to reflect the physician counseling work and practice expense inherent in the service.

As noted above, code 96372 was the same code used by CMS years earlier to value immunization administration code 90471. Both 96372 and 90471 describe the physician work of direct supervision whereas 90460 and 90461 describe a more intense level of physician work involving patient counseling.
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In addition to flawed methodology, there is a change in the patient population reflecting growing vaccine hesitancy. Although coverage levels for most childhood vaccines remain relatively high in the United States, numerous studies have documented that vaccine-related confidence has been decreasing among US parents over the past several years[1]. In 2011, only one in five physicians reported that a significant percentage of parents asked to spread out vaccines in a typical month. By 2014, that percentage had grown to 58% of respondents who reported frequent requests for alternative vaccination schedules[2]. Because altered vaccine schedules are associated with reduced vaccine rates and increase in vaccine administration errors, physician counseling is required to confront requests for alternative scheduling. **The RUC agreed that there is compelling evidence that the physician work has changed for these services due to flawed methodology in the recent CMS valuation and the patient population has changed.**

90460 ***Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered***
The RUC reviewed the survey results from 94 physicians and nurse practitioners and determined that the 25th percentile work RVU of 0.24 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time as supported by the survey. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from that which is included in the E/M visit.

The pediatric immunization administration codes, 90460 and 90461, require more physician work than the adult immunization administration codes 90471-90474, because they require physician/qualified health care professional counseling. Counseling is typically provided with the adult codes, but it is not required. Secondly, as indicated in the compelling evidence statement, there has been an increase in vaccination hesitancy, which requires counseling with the parents by reviewing a 5-page vaccination information sheet (VIS), discussing the safety, efficacy and health benefits of the vaccinations.

The specialty societies indicated that CPT code 90460 requires slightly more work and is more intense than the recent COVID-19 immunization administration services (work RVU = 0.20 and 7 minutes intra-service time). There are currently four COVID-19 vaccinations in the market, whereas there are approximately 30 different preparations of childhood vaccines on the market. Due to concerns that are often product specific, it increases the intensity and the breadth of the discussion/counseling with the parent for CPT codes 90460 and 90461.

The RUC compared the surveyed code to the top key reference service 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes intra-service time) and determined that these services both involve counseling on health risks for patients, require the exact same physician work and time, and therefore should be valued the same.

The RUC also compared 90460 to the second top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When*

[1] https://www.tandfonline.com/doi/full/10.4161/hv.25085
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242184/
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using time for code selection, 10-19 minutes of total time is spent on the date of the encounter (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined 90460 requires much less physician work and time to perform, thus is appropriately valued lower.

For additional support, the RUC referenced MPC codes 74019 *Radiologic examination, abdomen; 2 views* (work RVU = 0.23, 4 minutes of intra-service time and 6 minutes total time) and 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)* (work RVU = 0.25, 5 minutes of intra-service time and 10 minutes of total time), which require similar physician work and time. The RUC concluded that CPT code 90460 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.24 for CPT code 90460.**

90461 ***Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)*** The RUC reviewed the survey results from 91 physicians and nurse practitioners and determined that the 25th percentile work RVU of 0.18 appropriately accounts for the work required to perform this add-on service. The RUC recommends 5 minutes of intra-service time as supported by the survey. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

The pediatric immunization administration codes, 90460 and 90461, require more physician work than the adult immunization administration codes 90471-90474, because they require physician/qualified health care professional counseling. Counseling is typically provided with the adult codes, but it is not required. Secondly, as indicated in the compelling evidence statement, there has been an increase in vaccination hesitancy, which requires counseling with the parents by reviewing a 5-page VIS, discussing the safety, efficacy and health benefits of the vaccinations.

The RUC compared the surveyed code to the top key reference service 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.10- and 4-minutes intra-service time) and determined 90461 requires more physician work, time and intensity, thus should be valued higher.

The RUC also compared 90461 to the second top key reference service 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20, 4 minutes intra-service time and 7 minutes total time) and determined 90461 requires slightly less physician work and time to perform.

For additional support, the RUC referenced MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 3 minutes of intra-service time and 6 minutes total time) and 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19, 5 minutes of intra-service time and 6 minutes of total time), which require similar physician work and

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time. The RUC concluded that CPT code 90461 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.18 for CPT code 90461.**

90471 ***Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)***

The RUC reviewed the survey results from 100 physicians and nurse practitioners and determined that the current work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time. The RUC discussed that the survey respondents indicated the median time had decreased. However, after further inspection of the survey results, the specialty societies indicated that the survey median time was skewed by those who completed the survey because it was not representative of those who typically perform this service. Of the 100 survey responses, 83 were from pediatrics and only 17 were from other primary care organizations. The pediatricians are atypical users of the adult codes and do not spend the same amount of time counseling since they would report 90460 and 90461 in those instances. The 17 responses from other primary care organizations support the current time of 7 minutes, thus the RUC agreed there is no evidence to change the physician time. The specialty societies indicated that counseling is typical and provided in over 50% of the adult immunization administration codes 90471 and 90472; however, it is not required.

Survey Data Breakdown

CPT	Specialty	Responses	Response %	Median Time	2019 Medicare Claims Performance
90471	Pediatrics (AAP)	83	83%	3 min	0.5%
	Internal Med (ACP)	6	6%	5 min	26%
	Nurse Practitioners (ANA)	6	6%	9 min	17%
	Ob/Gyn (ACOG)	5	5%	9 min	0.3%
	Family Medicine (AAFP)	0			35%
	Total	100			

The RUC determined that the surveyed was flawed because the respondents who are not the predominant performers of this service skewed the results and further, there is no evidence that the current physician work or time has changed. The RUC concurred that the current work RVU of 0.17 and 7 minutes of intra-service time appropriately account for the work and time required to perform CPT code 90471. This valuation maintains the relativity and rank order with the pediatric immunization administration code, with 90471 being appropriately lower, as there is slightly less education and discussion about vaccination hesitancy that is required for CPT code 90460. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced CPT codes 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17, 3 minutes intra-service time and 7 minutes total time), 99211 *Office or other outpatient visit*

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for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (work RVU = 0.18, 5 minutes intra-service and 7 minutes total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time), all which require similar physician work and total time. The RUC concluded that the current value and time of CPT code 90471 should be maintained. **The RUC recommends a work RVU of 0.17 for CPT code 90471.**

90472 ***Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)***
The RUC discussed CPT code 90472 and came to the same determination, as for 90471, that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results. Of the 97 survey responses, 81 were from pediatrics and only 16 were from other primary care organizations. The pediatricians are atypical users of the adult codes and do not spend the same amount of time counseling since they would report 90460 and 90461 in those instances. The 16 responses from other primary care organizations support the current time of 7 minutes, thus the RUC agreed there is no evidence to change the physician time. The specialty societies indicated that counseling is typical and provided in over 50% of the adult immunization administration codes 90471 and 90472; however, it is not required.

Survey Data Breakdown

CPT	Specialty	Responses	Response %	Median Time	2019 Medicare Claims Performance
90472	Pediatrics (AAP)	81	84%	3 min	0.4%
	Internal Med (ACP)	6	6%	5 min	32%
	Nurse Practitioners (ANA)	5	5%	5 min	12%
	Ob/Gyn (ACOG)	5	5%	8 min	0.4%
	Family Medicine (AAFP)	0			42%
	Total	97			

The RUC determined that there is no evidence that the current physician work or time has changed. The RUC concurred that the current work RVU of 0.15 appropriately accounts for the work required to perform this add-on service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity with the pediatric immunization administration code, with 90472 being appropriately lower as there is slightly less education and discussion about vaccination hesitancy that is required for CPT code 90461. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced 78730 *Urinary bladder residual study (List separately in addition to code for primary procedure)* (work RVU = 0.15 and 5 minutes of intra-service and total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time). The RUC concluded that the current value and time of CPT code 90472 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 90472.**

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90473 ***Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)***
The RUC determined that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results and there is no evidence that the physician work and time has changed for this service.

The RUC agreed with the specialty societies that the work required for the intranasal/oral immunization administration is the same as the intramuscular immunization administration services. The RUC determined that the current work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity and rank order with the pediatric immunization administration code, with 90473 being appropriately lower, as there is slightly less education and discussion about vaccination hesitancy as is required for CPT code 90460. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced CPT codes 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17, 3 minutes intra-service time and 7 minutes total time), 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.* (work RVU = 0.18, 5 minutes intra-service and 7 minutes total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time), all which require similar physician work and time. The RUC concluded that the current value and time of CPT code 90473 should be maintained. **The RUC recommends a work RVU of 0.17 for CPT code 90473.**

90474 ***Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)***
The RUC determined that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results and there is no evidence that the physician work and time has changed for this service.

The RUC agreed with the specialty societies that the work required for the intranasal/oral immunization administration services are the same as the intramuscular immunization administration services. The RUC determined that the current work RVU of 0.15 appropriately accounts for the work required to perform this add-on service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity with the pediatric immunization administration code, with 90474 being appropriately lower as there is slightly less education and discussion about vaccination hesitancy as is required for CPT code 90461.

For additional support, the RUC referenced 78730 *Urinary bladder residual study (List separately in addition to code for primary procedure)* (work RVU = 0.15 and 5 minutes of intra-service/total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time). The RUC concluded that the current value and time of CPT code 90474 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 90474.**

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G0008 ***Administration of influenza virus vaccine***
G0009 ***Administration of pneumococcal vaccine***
G0010 ***Administration of hepatitis b vaccine***
HCPCS codes G0008, G0009 and G0010 for the administration of the vaccines are not paid on the Medicare Physician Fee Schedule. The Medicare Claims Processing Manual instructs that beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (recommended work RVU = 0.17 and 7 minutes intra-service time). The specialty societies indicated, and the RUC recommends maintaining that link. **The RUC recommends 7 minutes intra-service time and a work RVU of 0.17 for codes G0008, G0009 and G0010.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed and accepted compelling evidence based on flawed methodology due to CMS hard coding as well as change in technique, as detailed in the PE summary of recommendation (SOR). Based on acceptance of compelling evidence, the PE Subcommittee reviewed the direct practice expenses for these services. It was clarified that 3 minutes of CA011 *Provide education/obtain consent* is typical for all these immunization administration services. The specialty societies explained, and the PE Subcommittee agreed, that a vaccination information statement (VIS) is required by Federal law to be presented and reviewed with patients for every vaccine administered. Even if it is a yearly vaccination, individuals must be presented and informed of both the benefits and risks of the vaccine. The PE Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
Immunization Administration for Vaccines/Toxoids Report vaccine immunization administration codes 90460, 90461, 90471-90474 in addition to the vaccine and toxoid code(s) 90476-90749. Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474. (See also Instructions for Use of the CPT Codebook for definition of reporting qualifications.) If a significant separately identifiable evaluation and management service (eg, new or established patient office or other outpatient services [99202-99215], office or other outpatient consultations [99241-99245], emergency department services [99281-99285], preventive medicine services [99381-99429]) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.			

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A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism (90460 and 90461). Multi-valent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.			
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	XXX	0.24
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure) (Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine)	ZZZ	0.18
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) (Do not report 90471 in conjunction with 90473)	XXX	0.17 (No change)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (Use 90472 in conjunction with 90460, 90471, 90473) (For immune globulins, see 90281-90399. For administration of immune globulins, see 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96374) (For intravesical administration of BCG vaccine, see 51720, 90586)	ZZZ	0.15 (No change)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) (Do not report 90473 in conjunction with 90471)	XXX	0.17 (No change)

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90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (Use 90474 in conjunction with 90460, 90471, 90473)	ZZZ	0.15 (No change)
G0008	Administration of influenza virus vaccine	XXX	0.17 (Value is linked to 90471)
G0009	Administration of pneumococcal vaccine	XXX	0.17 (Value is linked to 90471)
G0010	Administration of hepatitis b vaccine	XXX	0.17 (Value is linked to 90471)

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March 26, 2021

Ezequiel Silva III, MD
Chairperson, AMA/Specialty Society RVS Update Committee (RUC)
AMA Plaza
330 N. Wabash Avenue
Suite 39300
Chicago, IL 60611-5885

RE: Tab 19: Immunization Administration (90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009, G0010): G Code Recommendations

Dear Doctor Silva:

Thank you for the opportunity to survey and provide recommendations for Tab 19 Immunization Administration. The undersigned specialties provide this letter as informational background, an explanation of our decision not to survey certain codes, as well as our valuation recommendations for codes G0008 *(Administration of influenza virus vaccine)*, G0009 *(Administration of pneumococcal vaccine)*, and *G0010 (Administration of hepatitis b vaccine)*.

As you know, as of March 1, 2003, the Medicare Claims Processing Manual instructs carriers to reimburse HCPCS codes G0008, G0009, and G0010 at the same rate as CPT code 90471 *(Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)).*

The specific language from page 49 of the manual states:

> *"The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, prior to March 1, 2003, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated contractor must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471."*

As a result of this explicit Medicare payment policy, the undersigned specialties do not believe it is necessary to survey or develop direct practice expense input recommendations for codes G0008, G0009, and G0010.

Our specialties support the current crosswalk between 90471 and these codes and believe that this crosswalk should be maintained. As such, following a robust survey response, our specialties are recommending a work RVU of 0.17 for CPT code 90471. ***Given existing Medicare payment policy, we encourage the RUC to also recommend to CMS a work RVU of 0.17 and identical direct practice expense inputs for codes G0008, G0009, and G0010.***

Thank you,
American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Nurses Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90460 Tracking Number Original Specialty Recommended RVU: **0.24**
Presented Recommended RVU: **0.24**
Global Period: XXX Current Work RVU: **0.17** RUC Recommended RVU: **0.24**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Counseling is provided when a 15-year-old patient is administered the Human Papilloma virus (HPV) vaccine.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified healthcare professional (QHP) discusses the specific risks/benefits of the first vaccine component including the risks associated with this component and the risks of not receiving it. Concepts related to herd immunity, relative risk, Vaccine Adverse Event Reporting System, and vaccine safety are discussed. The physician or other QHP addresses the parent 's questions regarding the safety and efficacy of this vaccine component. The physician or other QHP then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of the vaccine (e.g. soreness and pain at the injection site, fever) and reviews the signs or symptoms that warrant a call back.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association
CPT Code:	90460
Sample Size: 12828	**Resp N:** 94
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	325.00	**1000.00**	1788.00	30413.00
Survey RVW:	0.15	0.24	**0.27**	0.60	1.30
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	5.00	**7.00**	10.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code: 90460	**Recommended Physician Work RVU: 0.24**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99406	XXX	0.24	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74019	XXX	0.23	**RUC Time**	429,437

CPT Descriptor 1 Radiologic examination, abdomen; 2 views

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93922	XXX	0.25	**RUC Time**	694,382

CPT Descriptor 2 Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 26.5 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 25.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 90460	Top Key Reference CPT Code: 99406	2nd Key Reference CPT Code: 99212
Median Pre-Service Time	0.00	0.00	2.00
Median Intra-Service Time	7.00	7.00	11.00
Median Immediate Post-service Time	0.00	0.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**16.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	4%	0%	12%	56%	28%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	16%	32%	52%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	36%	60%
Physical effort required	8%	60%	32%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	20%	76%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	33%	38%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	38%	42%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	50%	42%
Physical effort required	13%	54%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	38%	54%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Compelling Evidence

For code 90460, the specialties recommend the survey 25th percentile of 0.24 work RVUs, which is greater than the current value of 0.17. In support of consideration of this higher work RVU, the specialties offer the following compelling evidence arguments.

First, the specialties believe the current value was arrived at via flawed methodology. The pediatric Immunization Administration codes 90460 and 90461 were developed to promote physician counseling of hesitant parents and use of combination vaccines to address decline in national immunization rates and subsequently valued by the RUC in October 2009. However, in the 2011 MPFS, CMS did not accept the RUC recommendations for 90460 and 90461. Instead, CMS applied the same methodology used for the existing Immunization Administration codes (90471-90474) to establish the values for 90460 and 90461. CMS valued codes 90471 and 90473 (base) codes by hard-coding them to code 96372 (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*) and then setting the RVUs for the add-on codes (90472 and 90474) at approximately half the value of the base codes. While CMS the values in and of themselves do not create flawed methodology, the process associated with valuing these codes is flawed for several reasons.

Unlike RUC crosswalking of codes to determine a one-time value, CMS hard-coded 90460 to 96372, meaning that when PE inputs for code 96372 were subsequently reduced by the RUC in January 2017, CMS automatically reduced the PE values for 90460 even though the same reductions in clinical staff time did not apply to 90460. These reductions threatened the US national vaccination program by reducing the value below the Medicaid minimum payment rate for immunization administration. The specialties then began working with CMS to identify an alternative crosswalk methodology to reflect the physician counseling work and practice expense inherent in the service.

In the 2021 MPFS proposed rule, CMS stated its belief that the hard-coding of 90460 to 96372 does not reflect the relative resource costs associated with these services (Source: CMS-1734-P (pages 266-270). Although CMS chose to maintain the hard-coding for 2021, it stated in the final rule that "*we would welcome the results of an updated formal review of these services as well as any additional information that may be helpful for improved valuation*" (Source: CMS 1734-F (page 157)). This statement and CMS's comments in the proposed rule indicate the current values are based on a flawed methodology.

In addition, the fact that both the RUC and CMS recently accepted the October 2009 RUC recommendations for code 90460 as the basis of a RUC crosswalk for all COVID Immunization Administration with physician counseling codes further supports that the hard coding of the Immunization Administration codes with counseling to 96372 was flawed and no longer an appropriate valuation.

As noted above, code 96372 was the same code used by CMS years earlier to value Immunization Administration code 90471. Both 96372 and 90471 describe the physician work of direct supervision whereas 90460 and 90461 describe a more intense type of physician work of patient counseling.

In addition to flawed methodology, there is a change in the patient population reflecting growing vaccine hesitancy. Although coverage levels for most childhood vaccines remain relatively high in the United States,[8,9] numerous studies have documented that vaccine-related confidence has been decreasing among US parents over the past several years (Source: https://www.tandfonline.com/doi/full/10.4161/hv.25085). In 2011, only one in five physicians reported that a significant percentage of parents asked to spread out vaccines in a typical month. By 2014, that had grown to 58% of respondents who reported frequent requests for alternative vaccination schedules (Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242184/). Because altered vaccine schedules are associated with reduced vaccine rates and increase in vaccine administration errors, physician counseling is required to confront requests for alternative scheduling.

Additional rationale to support recommended value

For code 90460, the specialties recommend the survey 25th percentile of 0.24 work RVUs and the survey median of 7 minutes intra-service time, which also serves as the total time. While the recommended RVW is higher than the current CMS hard-coded value of 0.17, the source code 96372 has only 3 minutes of intraservice time which supports that the RVW for 90460, with more than double the IST, should be higher than 0.17.

The recommended increase in work RVUs is also supported by increased intensity when providing this counseling service, because of the increase in number of vaccines recommended and the options presented and the details/footnotes on the

Advisory Committee on Immunization Practices' recommended schedule that must be considered with each vaccine component that is counseled in comparison to the last time this service was valued.

The recommended time and work are supported by the primary key reference service, 99406 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*), which has the same time and work RVUs as are recommended for code 90460. As with 90460, the bulk of the physician/QHP work for 99406 is counseling.

There are multiple other RUC-reviewed services with an XXX global period that have comparable times and work RVUs:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
88311	Decalcification procedure	XXX	0.24	0	5	2	7
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	XXX	0.24	0	7	0	7
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	XXX	0.24	0	7	0	7
77073	Bone length studies (orthoroentgenogram, scanogram	XXX	0.26	1	5	1	7
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral)	XXX	0.26	1	5	1	7
70260	Radiologic examination, skull; complete, minimum of 4 views	XXX	0.28	1	4	1	6

These examples illustrate that the recommended value and time for code 90460 are comparable to other services of other specialties in the resource-based relative value scale.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Code 90460 is typically reported in addition to an office visit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90460	XXX	0.24	0	7	0
5.	Total		1.54	5	27	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90460

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Medicine How often? Commonly

Specialty Pediatric Medicine How often? Commonly

Specialty Internal Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 109614651
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 75853338 Percentage 69.19 %

Specialty Nurse Practitioner Frequency 15126822 Percentage 13.80 %

Specialty Family Medicine Frequency 9755704 Percentage 8.90 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 301 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization in the RUC database.

Specialty Family Medicine Frequency 136 Percentage 45.18 %

Specialty Pediatrics Frequency 45 Percentage 14.95 %

Specialty Internal Medicine Frequency 40 Percentage 13.28 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90460

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90461 Tracking Number Original Specialty Recommended RVU: **0.18**
Presented Recommended RVU: **0.18**
Global Period: ZZZ Current Work RVU: **0.15** RUC Recommended RVU: **0.18**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Counseling is provided when a twelve-month-old patient is administered the measles, mumps, rubella (MMR) combination vaccine.
(Note: This is an add-on code for the additional physician/other qualified health care professional work related to the administration of one additional vaccine or toxoid component. The physician or other qualified health care professional work related to the administration of the first vaccine or toxoid component is reported separately with code 90460.)

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified healthcare professional (QHP) discusses the specific risks/benefits of each additional vaccine component including the risks associated with each additional component and the risk of not receiving each one. Concepts related to herd immunity, relative risk, Vaccine Adverse Event Reporting System, and vaccine safety are discussed. The physician or other QHP addresses the parent 's questions regarding the safety and efficacy of this vaccine component. The physician or other QHP then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of each vaccine component and reviews the signs or symptoms that warrant a call back.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C					
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association					
CPT Code:	90461					
Sample Size:	12828	**Resp N:**	91			
Description of Sample:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	217.00	**560.00**	1506.00	27775.00
Survey RVW:		0.10	0.18	**0.24**	0.40	1.30
Pre-Service Evaluation Time:				**0.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		1.00	3.00	**5.00**	7.00	18.00
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	90461	**Recommended Physician Work RVU: 0.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96375	ZZZ	0.10	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96411	ZZZ	0.20	**RUC Time**

CPT Descriptor Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	18,866,949

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
96367	ZZZ	0.19	**RUC Time**	1,292,846

CPT Descriptor 2 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 25.2 **%**

Number of respondents who choose 2nd Key Reference Code: 22 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 90461	Top Key Reference CPT Code: 96375	2nd Key Reference CPT Code: **96411**
Median Pre-Service Time	0.00	0.00	3.00
Median Intra-Service Time	5.00	4.00	4.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**5.00**	**4.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	4%	9%	39%	30%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	35%	48%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	22%	65%	13%

Physical effort required	17%	52%	30%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	30%	57%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	5%	18%	41%	36%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	32%	41%	27%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	23%	59%	18%
Physical effort required	32%	55%	14%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	36%	27%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Compelling Evidence

For code 90461, the specialties recommend the survey 25th percentile of 0.18 work RVUs, which is greater than the current value of 0.15. In support of consideration of this higher work RVU, the specialties offer the following compelling evidence arguments.

First, the current values for the Immunization Administration codes are based on a CMS hard-coding to code 96372 (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*) rather than using the RUC recommended value. Unlike code 90461, 96372 does not include patient counseling.

Code 96372 was reviewed by the RUC in January 2017. CMS subsequently accepted changes to the practice expense inputs that led to steadily decreasing practice expense RVUs for that code and, by extension, the Immunization Administration codes that were hard-coded to 96372.

In the 2021 MPFS proposed rule, CMS stated its belief that that this valuation methodology does not reflect the relative resource costs associated with these services (Source: CMS-1734-P (pages 266-270). Although CMS chose to maintain the hard-coding for 2021, it stated in the final rule that "*we would welcome the results of an updated formal review of these services as well as any additional information that may be helpful for improved valuation*" (Source: CMS 1734-F (page 157). This statement and CMS's comments in the proposed rule indicate the current values are based on a flawed methodology. Additional evidence of the methodological flaw in hard-coding 96372 to 90461 is found in the fact that it resulted in the assignment of direct practice expenses to 90461 despite the fact the code only describes the work of physician/QHP vaccine counseling.

In addition to flawed methodology, there is a change in the patient population reflecting growing vaccine hesitancy. Although coverage levels for most childhood vaccines remain relatively high in the United States,[8,9] numerous studies have documented that vaccine-related confidence has been decreasing among US parents over the past several years (Source: https://www.tandfonline.com/doi/full/10.4161/hv.25085). In 2011, only one in five physicians reported that a significant percentage of parents asked to spread out vaccines in a typical month. By 2014, that had grown to 58% of respondents who reported frequent requests for alternative vaccination schedules (Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242184/). Because altered vaccine schedules are associated with reduced vaccine rates and increase in vaccine administration errors, physician counseling is required to confront requests for alternative scheduling.

Additional rationale to support recommended value

For code 90461, the specialties recommend the survey 25th percentile of 0.18 work RVUs and the survey median of 5 minutes intra-service time, which also serves as the total time, because there is no pre- or post-service time associated with this code.

The recommended increase in work RVUs is supported by increased intensity when providing this counseling service, because of the increase in number of vaccines recommended and the options presented and the details/footnotes on the Advisory Committee on Immunization Practices' recommended schedule that must be considered with each vaccine component that is counseled in comparison to the last time this service was valued.

Other RUC-reviewed codes with a ZZZ global period and comparable time and work RVUs include:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug	ZZZ	0.10	0	4	0	4
96366	Intravenous infusion, for therapy, prophylaxis,	ZZZ	0.18	0	5	0	5

	or diagnosis (specify substance or drug); each additional hour						
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered	ZZZ	0.18	0	5	0	5
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour	ZZZ	0.18	0	5	0	5
96415	Chemotherapy administration, intravenous infusion technique; each additional hour	ZZZ	0.19	0	5	0	5

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☒ Other reason (please explain) The base code (90460) is typically reported in addition to an office vsit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90460	XXX	0.24	0	7	0
5.	90461	ZZZ	0.18	0	5	0
6.	Total		1.72	5	32	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90461

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Medicine How often? Commonly

Specialty Family Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 79173313
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 54787933 Percentage 69.20 %

Specialty Nurse Practitioner Frequency 10925917 Percentage 13.79 %

Specialty Family Medicine Frequency 7046425 Percentage 8.90 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 58 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (RUC database.)

Specialty Pediatrics Frequency 31 Percentage 53.44 %

Specialty Family Medicine Frequency 17 Percentage 29.31 %

Specialty Nurse Practitioner Frequency 6 Percentage 10.34 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90461

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90471 Tracking Number Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: XXX Current Work RVU: **0.17** RUC Recommended RVU: **0.17**

CPT Descriptor: Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intramuscular injection of seasonal influenza vaccine.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: In accordance with national recommendations for immunizations, determine the patient should receive recommended vaccination. Communicate vaccine order to clinical staff.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association
CPT Code:	90471
Sample Size: 12828	**Resp N:** 100
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**216.00**	500.00	7501.00
Survey RVW:	0.10	0.18	**0.20**	0.30	0.75
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	2.00	**4.00**	7.00	20.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code: 90471	**Recommended Physician Work RVU: 0.17**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99211	XXX	0.18	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99188	XXX	0.20	**RUC Time**

CPT Descriptor Application of topical fluoride varnish by a physician or other qualified health care professional

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73120	XXX	0.16	**RUC Time**	278,753

CPT Descriptor 1 Radiologic examination, hand; 2 views

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99211	XXX	0.18	**RUC Time**	2,684,197

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 38 **% of respondents:** 38.0 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 21.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 90471	Top Key Reference CPT Code: 99211	2nd Key Reference CPT Code: **99188**
Median Pre-Service Time	0.00	99188.00	2.00
Median Intra-Service Time	7.00	7.00	5.00
Median Immediate Post-service Time	0.00	0.00	2.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**9.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	53%	37%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	74%	16%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	63%	26%

Physical effort required	8%	68%	24%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	32%	58%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	33%	48%	19%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	19%	71%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	24%	52%	24%
Physical effort required	33%	43%	24%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	0%	95%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Additional rationale to support recommended value

The specialties recommend maintaining the current work RVUs of 0.17 for this service, which is less than the 25th percentile of our survey. We recommend the survey median of 4 minutes for intra-service and total time.

While the recommended intra-service time of 4 minutes is nominally less than the intra-service time currently shown for this code, it is greater than the 3 minutes of intra-service time for 96372, to which the value of 90471 is currently hard-coded. Despite that greater intra-service time, we are recommending maintaining the current value of 0.17, which is the same as 96372.

The recommended value is less than the 0.18 work RVUs assigned to key reference service 99211 (Level 1 established patient office visit), which has 5 minutes of intra-service time. It is also less than the 0.18 work RVUs assigned to code 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older), which has only 3.2 minutes of intra-service and total time.

A comparison of the recommended value and time with the key reference services and other services follows:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
94781	Car seat/bed testing for airway integrity, for infants through 12 months of age, with continual clinical staff observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes	ZZZ	0.17	0	5	0	5
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	XXX	0.17	0	4	0	4
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	XXX	0.18	0	3.2	0	3.2
99211	Office or other outpatient visit for the evaluation and	XXX	0.18	0	5	2	7

	management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.						
99188	Application of topical fluoride varnish by a physician or other qualified health care professional	XXX	0.20	2	5	2	9

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Code 90471 is typically reported in addition to an office visit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90471	XXX	0.17	0	4	0
5.	Total		1.47	5	24	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90471

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Medicine How often? Commonly

Specialty Internal Medicine How often? Commonly

Specialty Nurse Practitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 162160552
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Family Medcine Frequency 39832832 Percentage 24.56 %

Specialty Nurse Practitioner Frequency 35557273 Percentage 21.92 %

Specialty Pediatrics Frequency 21719251 Percentage 13.39 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 282,357 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database.

Specialty Family Medicine Frequency 99672 Percentage 35.29 %

Specialty Internal Medicine Frequency 73130 Percentage 25.89 %

Specialty Nurse Practitioner Frequency 47718 Percentage 16.89 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90471

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90472 Tracking Number Original Specialty Recommended RVU: **0.15**
Presented Recommended RVU: **0.15**
Global Period: ZZZ Current Work RVU: **0.15** RUC Recommended RVU: **0.15**

CPT Descriptor: Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: After a patient receives an intramuscular vaccine (reported separately), she receives an additional intramuscular vaccine.
(Note: This is an add-on code for the additional physician or other qualified health care professional work related to the administration of one additional vaccine (single or combination vaccine/toxoid). The physician or other qualified health care professional work for the administration of the first vaccine (single or combination vaccine/toxoid) is reported separately with code 90471.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: In accordance with national recommendations for immunizations, determine the patient should receive recommended vaccination. Communicate vaccine order to clinical staff.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association
CPT Code:	90472
Sample Size: 12828	**Resp N:** 97
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**25.00**	100.00	6496.00
Survey RVW:	0.09	0.15	**0.20**	0.25	2.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	2.00	**3.00**	5.00	25.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code: 90472	**Recommended Physician Work RVU: 0.15**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96375	ZZZ	0.10	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96411	ZZZ	0.20	**RUC Time**

CPT Descriptor Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
96375	ZZZ	0.10	**RUC Time**	1,416,745

CPT Descriptor 1 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73120	XXX	0.16	**RUC Time**	278,753

CPT Descriptor 2 Radiologic examination, hand; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 40 **% of respondents:** 41.2 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 90472	**Top Key Reference CPT Code:** 96375	**2nd Key Reference CPT Code:** **96411**
Median Pre-Service Time	0.00	0.00	3.00
Median Intra-Service Time	7.00	4.00	4.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**4.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	8%	10%	50%	28%	5%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	60%	20%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	20%	70%	10%

Physical effort required	18%	60%	23%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	15%	50%	35%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	65%	29%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	59%	12%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	76%	12%
Physical effort required	24%	65%	12%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	24%	41%	35%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Additional rationale to support recommended value
The specialties recommend maintaining the current work RVUs of 0.15 for this service, which is also the 25th percentile of our survey. We recommend the survey median of 3 minutes for intra-service and total time.

While the recommended intra-service time of 3 minutes is nominally less than the intra-service time currently shown for this code, it is equal to the 3 minutes of intra-service time for 96372, to which 90472 is currently hard-coded. Despite that equal intra-service time, we are recommending maintaining the current value of 0.15, which is less than the value of 0.17 assigned to 96372.

A comparison of the recommended value and time with the key reference services and other services follows:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug	ZZZ	0.10	0	4	0	4
73020	Radiologic examination, shoulder; 1 view	XXX	0.15	1	3	1	5
78730	Urinary bladder residual study	ZZZ	0.15	0	5	0	5
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid)	ZZZ	0.15	0	3	0	3
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	XXX	0.18	0	3.2	0	3.2
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour	ZZZ	0.18	0	5	0	5
96411	Chemotherapy administration;	ZZZ	0.20	3	4	0	7

	intravenous, push technique, each additional substance/drug						

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) The base code (90471) is typically reported in addition to an office vsit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90471	XXX	0.17	0	4	0
5.	90472	ZZZ	0.15	0	3	0
6.	Total		1.62	5	27	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90472

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Medicine How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 24321832
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 9531944 Percentage 39.19 %

Specialty Nurse Practitioner Frequency 4421664 Percentage 18.17 %

Specialty Family Medicine Frequency 4212635 Percentage 17.32 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 22,524
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet; frequency and percentages are from the 2019 Medicare utilization in the RUC database.)

Specialty Family Medicine Frequency 9415 Percentage 41.79 %

Specialty Internal Medicine Frequency 7208 Percentage 32.00 %

Specialty Nurse Practitioner Frequency 2748 Percentage 12.20 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90472

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90473 Tracking Number Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: XXX Current Work RVU: **0.17** RUC Recommended RVU: **0.17**

CPT Descriptor: Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intranasal administration of seasonal influenza vaccine.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: In accordance with national recommendations for immunizations, determine the patient should receive recommended vaccination. Communicate vaccine order to clinical staff.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C					
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association					
CPT Code:	90473					
Sample Size:	12828	**Resp N:**	83			
Description of Sample:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**13.00**	113.00	2000.00
Survey RVW:		0.10	0.18	**0.20**	0.27	1.00
Pre-Service Evaluation Time:				**0.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		0.00	2.00	**3.00**	6.00	12.00
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	90473	**Recommended Physician Work RVU: 0.17**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99211	XXX	0.18	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99188	XXX	0.20	**RUC Time**

CPT Descriptor Application of topical fluoride varnish by a physician or other qualified health care professional

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73120	XXX	0.16	**RUC Time**	278,753

CPT Descriptor 1 Radiologic examination, hand; 2 views

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99211	XXX	0.18	**RUC Time**	2,684,197

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 36 **% of respondents:** 43.3 **%**

Number of respondents who choose 2nd Key Reference Code: 20 **% of respondents:** 24.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 90473	**Top Key Reference CPT Code:** 99211	**2nd Key Reference CPT Code:** **99188**
Median Pre-Service Time	0.00	0.00	2.00
Median Intra-Service Time	7.00	5.00	5.00
Median Immediate Post-service Time	0.00	0.00	2.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**9.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	3%	8%	50%	36%	3%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	19%	58%	22%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	61%	33%

Physical effort required	8%	61%	31%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	36%	61%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	25%	50%	20%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	25%	70%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	20%	45%	35%
Physical effort required	45%	40%	15%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	5%	95%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Additional rationale to support recommended value

The specialties recommend maintaining the current work RVUs of 0.17 for this service, which is less than the 25th percentile of our survey. We recommend the survey median of 3 minutes for intra-service and total time.

While the recommended intra-service time of 3 minutes is nominally less than the intra-service time currently shown for this code, it is equal to the 3 minutes of intra-service time for 96372, to which the value of 90473 is currently hard-coded. Consistent with the equal intra-service time, we are recommending maintaining the current value of 0.17, which is equal to the value of 0.17 assigned to 96372.

The recommended value is less than the 0.18 work RVUs assigned to key reference service 99211 (Level 1 established patient office visit), which has 5 minutes of intra-service time. It is also less than the 0.18 work RVUs assigned to code 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older), which has 3.2 minutes of intra-service and total time.

A comparison of the recommended value and time with the key reference services and other services follows:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
94781	Car seat/bed testing for airway integrity, for infants through 12 months of age, with continual clinical staff observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes	ZZZ	0.17	0	5	0	5
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	XXX	0.17	0	3	0	3
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	XXX	0.18	0	3.2	0	3.2
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the	XXX	0.18	0	5	2	7

	presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.						
99188	Application of topical fluoride varnish by a physician or other qualified health care professional	XXX	0.20	2	5	2	9

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) We expect code 90473 would typically be reported in addition to an office visit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90473	XXX	0.17	0	3	0
5.	Total		1.47	5	23	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90473

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Medicine How often? Rarely

Specialty Internal Medicine How often? Rarely

Specialty Nurse Practitioner How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 201822
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 139661 Percentage 69.20 %

Specialty Nurse Practitioner Frequency 27851 Percentage 13.79 %

Specialty Family Medicine Frequency 17962 Percentage 8.89 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization in the RUC database.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90473

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90474 Tracking Number Original Specialty Recommended RVU: **0.15**
Presented Recommended RVU: **0.15**
Global Period: ZZZ Current Work RVU: **0.15** RUC Recommended RVU: **0.15**

CPT Descriptor: Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: After a patient receives an intramuscular vaccine (reported separately), she receives an additional vaccine administered intranasally.
(Note: This is an add-on code for the additional physician or other qualified health care professional work related to the administration of one additional vaccine (single or combination vaccine/toxoid). The physician or other qualified health care professional work for the administration of the first vaccine (single or combination vaccine/toxoid) is reported separately with code 90473.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: In accordance with national recommendations for immunizations, determine the patient should receive recommended vaccination. Communicate vaccine order to clinical staff.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Megan Adamson, MD, MHS-CL, Jon Hathaway, MD, PhD, Tanvir Hussain, MD, Steven Krug, MD, Suzanne Berman, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA, Elisabeth Volpert DNP, APRN, FNP-C					
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association					
CPT Code:	90474					
Sample Size:	12828	**Resp N:**	80			
Description of Sample:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	17.00	1500.00
Survey RVW:		0.08	0.15	**0.18**	0.23	1.00
Pre-Service Evaluation Time:				**0.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		0.00	2.00	**3.00**	5.00	12.00
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	90474	**Recommended Physician Work RVU: 0.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96375	ZZZ	0.10	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96370	ZZZ	0.18	**RUC Time**

CPT Descriptor Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
96375	ZZZ	0.10	**RUC Time**	1,416,745

CPT Descriptor 1 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73120	XXX	0.16	**RUC Time**	278,753

CPT Descriptor 2 Radiologic examination, hand; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 33 **% of respondents:** 41.2 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 90474	Top Key Reference CPT Code: 96375	2nd Key Reference CPT Code: 96370
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	4.00	5.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**4.00**	**5.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	15%	55%	21%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	24%	61%	15%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	27%	67%	6%
Physical effort required	18%	64%	18%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	15%	52%	33%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	64%	21%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	57%	14%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	43%	43%	14%
Physical effort required	43%	43%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	57%	21%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Additional rationale to support recommended value
The specialties recommend maintaining the current work RVUs of 0.15 for this service, which is also the 25th percentile of our survey. We recommend the survey median of 3 minutes for intra-service and total time.

While the recommended intra-service time of 3 minutes is nominally less than the intra-service time currently shown for this code, it is equal to the 3 minutes of intra-service time for 96372, to which 90474 is currently hard-coded. Despite that equal intra-service time, we are recommending maintaining the current value of 0.15, which is less than the value of 0.17 assigned to 96372.

A comparison of the recommended value and time with the key reference services and other services follows:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug	ZZZ	0.10	0	4	0	4
73020	Radiologic examination, shoulder; 1 view	XXX	0.15	1	3	1	5
78730	Urinary bladder residual study	ZZZ	0.15	0	5	0	5
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)	ZZZ	0.15	0	3	0	3
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	XXX	0.18	0	3.2	0	3.2
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each	ZZZ	0.18	0	5	0	5

	additional hour						
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug	ZZZ	0.20	3	4	0	7

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) We expect the base code (90473) is typically reported in addition to an office vsit E/M

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99213	XXX	1.30	5	20	5
4.	90473	XXX	0.17	0	3	0
5.	90472	ZZZ	0.15	0	3	0
6.	Total		1.62	5	26	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90474

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Medicine How often? Rarely

Specialty Internal Medicine How often? Rarely

Specialty Nurse Practitioner How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1003452
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Pediatrics Frequency 694389 Percentage 69.20 %

Specialty Nurse Practitioner	Frequency 138476	Percentage 13.79 %
Specialty Family Medicine	Frequency 89307	Percentage 8.89 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet; frequency and percentages are from the 2019 Medicare utilization in the RUC database.)

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency 0	Percentage	%

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90474

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Immunization Administration

TAB: 19

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99406	XXX	Smoking and tobacco use cessation counseling visit;	2007	25	0.034	0.034			0.24			7						7								
2nd REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019	24	0.053	0.044			0.70			16	2					11			3					
CURRENT	90460	XXX	Immunization administration through 18 years of age via any	2009		0.024	0.024			0.17			7						7								
SVY	90460	XXX	Immunization administration through 18 years of age via any		94	0.039	0.039	0.15	0.24	0.27	0.60	1.30	7				1	5	7	10	20		0	325	###	###	30413
REC	90460	XXX	Immunization administration through 18 years of age via any			0.034	0.034			0.24			7						7								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	96375	ZZZ	Therapeutic, prophylactic, or diagnostic injection (specify	2017	23	0.025	0.025			0.10			4						4								
2nd REF	96411	ZZZ	Chemotherapy administration; intravenous, push technique,	2017	22	0.033	0.029			0.20			7	3					4								
CURRENT	90461	ZZZ	Immunization administration through 18 years of age via any	2009		0.030	0.030			0.15			5						5								
SVY	90461	ZZZ	Immunization administration through 18 years of age via any		91	0.048	0.048	0.10	0.18	0.24	0.40	1.30	5				1	3	5	7	18		0	217	560	###	27775
REC	90461	ZZZ	Immunization administration through 18 years of age via any			0.036	0.036			0.18			5						5								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99211	XXX	Office or other outpatient visit for the evaluation and	2019	38	0.027	0.026			0.18			7						5			2					
2nd REF	99188	XXX	Application of topical fluoride varnish by a physician or other	2014	21	0.022	0.022			0.20			9	2					5			2					
CURRENT	90471	XXX	Immunization administration (includes percutaneous,	2009		0.024	0.024			0.17			7						7								
SVY	90471	XXX	Immunization administration (includes percutaneous,		100	0.050	0.050	0.10	0.18	0.20	0.30	1.75	4				0	2	4	7	20		0	50	216	500	7501
REC	90471	XXX	Immunization administration (includes percutaneous,			0.024	0.024			0.17			7						7								

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
15					RUC			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
39					RUC			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
40	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
41	1st REF	96375	ZZZ	Therapeutic, prophylactic, or diagnostic injection (specify	2017	40	0.025	0.025			0.10			4						4								
42	2nd REF	96411	ZZZ	Chemotherapy administration; intravenous, push technique,	2017	17	0.033	0.029			0.20			7	3					4								
43	CURRENT	90472	ZZZ	Immunization administration (includes percutaneous,	2009		0.021	0.021			0.15			7						7								
44	SVY	90472	ZZZ	Immunization administration (includes percutaneous,		97	0.067	0.067	0.09	0.15	0.20	0.25	2.00	3				0	2	3	5	25		0	5	25	100	6496
45	REC	90472	ZZZ	Immunization administration (includes percutaneous,			0.021	0.021			0.15			7						7								
46																												
47					RUC			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
48	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
49	1st REF	99211	XXX	Office or other outpatient visit for the evaluation and	2019	36	0.027	0.026			0.18			7						5			2					
50	2nd REF	99188	XXX	Application of topical fluoride varnish by a physician or other	2014	20	0.022	0.022			0.20			9	2					5			2					
51	CURRENT	90473	XXX	Immunization administration by intranasal or oral route; 1	2009		0.024	0.024			0.17			7						7								
52	SVY	90473	XXX	Immunization administration by intranasal or oral route; 1		83	0.067	0.067	0.10	0.18	0.20	0.27	1.00	3				0	2	3	6	12		0	0	13	113	2000
53	REC	90473	XXX	Immunization administration by intranasal or oral route; 1			0.024	0.024			0.17			7						7								
54																												
55					RUC			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
56	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
57	1st REF	96375	ZZZ	Therapeutic, prophylactic, or diagnostic injection (specify	2017	33	0.025	0.025			0.10			4						4								
58	2nd REF	96370	ZZZ	Subcutaneous infusion for therapy or prophylaxis (specify	2007	14	0.036	0.036			0.18			5						5								
59	CURRENT	90474	ZZZ	Immunization administration by intranasal or oral route; each	2009		0.021	0.021			0.15			7						7								
60	SPR=0	90474	ZZZ	Immunization administration by intranasal or oral route; each		41	0.090	0.090	0.09	0.13	0.18	0.22	0.52	2				0	2	2	5	12		0	0	0	0	0
61	SPR>0	90474	ZZZ	Immunization administration by intranasal or oral route; each		39	0.060	0.060	0.08	0.15	0.18	0.28	1.00	3				0	2	3	5	9		1	9	20	100	1500
62	SVY	90474	ZZZ	Immunization administration by intranasal or oral route; each		80	0.060	0.060	0.08	0.15	0.18	0.23	1.00	3				0	2	3	5	12		0	0	0	17	1500
63	REC	90474	ZZZ	Immunization administration by intranasal or oral route; each			0.021	0.021			0.15			7						7								
64																												
65																												

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
15					RUC Review Year		IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC		Resp			MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
66					RUC Review Year		IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
67	Source	CPT	Global	DESC		Resp			MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
68	CURRENT CMS Crosswalk	G0008	XXX	Administration of influenza virus vaccine			0.024	0.024			0.17			7						7								
69	REC	90471	XXX	Immunization administration (includes percutaneous,			0.024	0.024			0.17			7						7								
70	REC	G0008	XXX	Administration of influenza virus vaccine			0.024	0.024			0.17			7						7								
71																												
72																												
73					RUC Review Year		IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
74	Source	CPT	Global	DESC		Resp			MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
75	CURRENT CMS Crosswalk	G0009	XXX	Administration of pneumococcal vaccine			0.024	0.024			0.17			7						7								
76	REC	90471	XXX	Immunization administration (includes percutaneous,			0.024	0.024			0.17			7						7								
77	REC	G0009	XXX	Administration of pneumococcal vaccine			0.024	0.024			0.17			7						7								
78																												
79																												
80					Review Year		IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
81	Source	CPT	Global	DESC		Resp			MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
82	CURRENT CMS Crosswalk	G0010	XXX	Administration of hepatitis b vaccine			0.024	0.024			0.17			7						7								
83	REC	90471	XXX	Immunization administration (includes percutaneous,			0.024	0.024			0.17			7						7								
84	REC	G0010	XXX	Administration of hepatitis b vaccine			0.024	0.024			0.17			7						7								

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 90460, 90461
SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, ANA, AAP
PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Korinne Van Keuren, DNP; Elisabeth Volpert, DNP; Steven Krug, MD; Suzanne Berman, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	XXX
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
90460	Counseling is provided when a 15-year-old patient is administered the Human Papilloma virus (HPV) vaccine.
90461	Counseling is provided when a twelve-month-old patient is administered the measles, mumps, rubella (MMR) combination vaccine. (Note: This is an add-on code for the additional physician/other qualified health care professional work related to the administration of one additional vaccine or toxoid component. The physician or other qualified health care professional work related to the administration of the first vaccine or toxoid component is reported separately with code 90460.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We convened a Practice Expense (PE) Expert Panel consisting of 15 individuals representing AAFP (RUC Advisor and Alternate RUC Advisor), ACOG (RUC Advisor), ANA (Alternate RUC/HCPAC Advisor and PE Subcommittee member), and AAP (RUC Advisor and members of the AAP Section on Administration & Practice Management and the AAP Pediatric Practice Management Alliance). After an initial virtual kick-off meeting, we surveyed Panel members on typical clinical activities, medical supplies, and medical equipment utilized in the service of immunization administration (IA). Survey results were compiled and shared via email, allowing Panel members to reach consensus on direct PE input recommendations for the IA codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   90460 and 90461 are existing codes; therefore, we are using their current direct PE inputs as their reference codes. However, we are also offering COVID IA code 0031A as a reference code. While

administration of the COVID-19 vaccine is unique, the fact that the RUC recently reviewed seven (7) new COVID IA codes imparts relevance on the inclusion of 0031A as a reference for the IA codes.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Codes 90460 and 90461 are typically reported with an E/M service. Codes 90460 and 90461 are typically reported with the E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

90460: nonfacility Family Medicine (45.5%); for all sites Family Medicine (45.2%) 90461: nonfacility Pediatric Medicine (53.4%); for all sites Pediatric Medicine (53.4%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are recommending a net decrease of $0.76 for the Immunization Administration (IA) code family: Current inputs for family = $35.49 Recommended inputs for family = $34.73 Net decrease = $0.76 **Please note that this calculation includes the current projected inputs ($3.98) for code 90461 based upon the current CMS crosswalk for this code. Code 90461 should not have any direct PE inputs and, therefore, negligible PE RVUs (due entirely to indirect PE). This is due to the fact that 90461 represents the physician/QHP counseling (ie, work only) required for each additional component in a multicomponent vaccine.** **However, based on the fact that the IA family has been hard-coded since its inception, CMS has assigned it PE RVUs equivalent with 90472 (0.21). Therefore, we have replicated the current direct PE inputs for code 90472 for code 90461. [PLEASE SEE PINK COLUMN IN PE SPREADSHEET.]**

In light of the above, we are technically not required to offer PE compelling evidence arguments. However, we provide the following information in support of our direct PE input recommendations.

Flawed Methodology

Since the Immunization Administration (IA) codes' inception, the Centers for Medicare and Medicaid Services (CMS) has valued them by hard-coding them to 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) (formerly code 90772 and then code 90782), rather than by utilizing RUC-recommendations to establish their values. CMS' decision to hard-code the base IA codes (90460, 90471, 90473) to 96372 and then value the add-on IA codes (90461, 90472, 90474) at approximately half of the base IA codes was flawed. This is illustrated by the fact 90461 is currently valued the same as 90472 and 90474, even though 90461 does contain any direct PE inputs. Code 90461 only reflects the physician/QHP work of vaccine counseling on each additional vaccine component.

Change in Clinical Staff Immunization Protocols

Immunization confirmation protocols have changed since the Immunization Administration codes were last valued due to the explosion in the number of new vaccines introduced since 2009. For example, there are 15 difference influenza vaccine presentations available today. This perhaps explains why 20% of all vaccine error reports have to do with influenza vaccine.

While electronic health records (EHRs) offer vaccine clinical decision support to predict (although not 100% accurately) the antigens required, they do not give decision support on the brand and presentation of a vaccine. Physicians/QHPs typically give orders for the antigen (eg, DTaP), but not the particular brand and presentation (eg, Daptacel, Infanrix, Kinrix, Pediarix, Pentacel, or Quadracel). Determining which of these vaccine products to use is a clinical staff decision, based on the patient's age and vaccination history.

This is further complicated by the fact that combination vaccines may only be used in some instances (eg, Kinrix (DTaP-IPV) can be given to patients who need both DTaP and IPV, but only if the patient is between ages 4-6, has had four prior doses of DTaP, and at least two prior doses of IPV). Additionally, some vaccines have different dosing requirements based on age (Hep A, Hep B, influenza), while others are the same regardless of patient age.

Finally, while the Advisory Committee on Immunization Practices (ACIP) recommends that a vaccine series be completed with the same brand whenever possible, in some cases it is acceptable to use the alternative brand in stock if the original brand is not known (DTaP), while, in other cases, using only the brand from the original dose is acceptable (MenB).

Change in ACIP Immunization Monitoring Time Recommendations (CA022)

The Advisory Committee on Immunization Practices (ACIP) recommends that "vaccine providers, particularly when vaccinating adolescents, should consider observing patients (with patients seated or lying down) for 15 minutes after vaccination to decrease the risk for injury should they faint" (please see https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf (page 71)). The ACIP recommendation has become more specific (in terms of time, description of patients who are at-risk for syncope, and position) since the IA codes were last valued.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Use of Total Clinical Staff Time in Calculating Equipment Usage
In February 2008, the RUC established a precedent for the Immunization Administration codes in that it recommended the total vaccine clinical staff time as the time of refrigerator/freezer use, rather than just the intra-service clinical staff time used in CMS' PE methodology. Our use of total clinical staff time to establish equipment recommendations accounts for a portion of the increase in the aggregate cost of direct PE inputs for the Immunization Administration codes.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We allocated 0 minutes to obtain vital signs and, therefore, are requesting no CST.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

CA007: Confirming vaccine order/checking appropriateness for patient
CA008: Checking historical and current temperatures for vaccine refrigerator; recording temperatures; reporting temperatures; vaccine inventorying; ordering vaccines; completing required Vaccines for Children (VFC) paperwork; receiving vaccines; inspecting/logging vaccines and putting them in the vaccine refrigerator; creating lot numbers in EHR

   b. Service period (includes pre, intra and post):

CA011: Giving Vaccine Information Sheet (VIS) to patient/family; getting informed consent and signature if applicable
CA014: Going to laboratory and taking vaccine vials out of vaccine refrigerator; drawing up vaccine into syringe; going back to patient room and preparing patient/parent, confirming that this is correct patient-correct vaccine
CA021: Actual administration of vaccine; bandage application
CA022: Watching patient after vaccine is administered
CA024: Disposal of vaccine-specific medical waste
CA034: Charting administered immunizations in the patient chart and EMR; preparing patient record/immunization card

   c. Post-service period:

CA037: Contacting patient/parent to follow up on immunization administration

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

CA021: RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, selects and prepares the injection site, administers the vaccine, and applies a bandage to the injection site. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
No, we are not recommending a PE supply pack.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) (NEW, line 113)

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

10 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Formula: Default
Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043)
Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43)

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Please note that we are recommending zero direct PE inputs for code 90461. This is due to the fact that it represents the physician/QHP counseling (ie, work only) required for each additional component in a multicomponent vaccine.

Please note under Medical Equipment:
Line 111 (ED043): While its description begins with "refrigerator, vaccine," it is the **temperature monitor with alarm** for the vaccine medical grade refrigerator (NEW, line 113). **We do not have two vaccine refrigerators included as part of our recommended medical equipment.**

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 90471, 90472
SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, ANA, AAP
PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Korinne Van Keuren, DNP; Elisabeth Volpert, DNP; Steven Krug, MD; Suzanne Berman, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	XXX
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
90471	A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intramuscular injection of seasonal influenza vaccine.
90472	After a patient receives an intramuscular vaccine (reported separately), she receives an additional intramuscular vaccine. (Note: This is an add-on code for the additional physician or other qualified health care professional work related to the administration of one additional vaccine (single or combination vaccine/toxoid). The physician or other qualified health care professional work for the administration of the first vaccine (single or combination vaccine/toxoid) is reported separately with code 90471.)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We convened a Practice Expense (PE) Expert Panel consisting of 15 individuals representing AAFP (RUC Advisor and Alternate RUC Advisor), ACOG (RUC Advisor), ANA (Alternate RUC/HCPAC Advisor and PE Subcommittee member), and AAP (RUC Advisor and members of the AAP Section on Administration & Practice Management and the AAP Pediatric Practice Management Alliance). After an initial virtual kick-off meeting, we surveyed Panel members on typical clinical activities, medical supplies, and medical equipment utilized in the service of immunization administration (IA). Survey results were compiled and shared via email, allowing Panel members to reach consensus on direct PE input recommendations for the IA codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   90471 and 90472 are existing codes; therefore, we are using their current direct PE inputs as their reference codes. However, we are also offering COVID IA code 0031A as a reference code. While administration of the COVID-19 vaccine is unique, the fact that the RUC recently reviewed seven (7) new COVID IA codes imparts relevance on the inclusion of 0031A as a reference for the IA codes.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

NOTE: Please see attached document "90471-4 Current Direct PE Inputs" for information on how the current direct PE inputs for codes 90471 and 90472 were established.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Codes 90471 and 90472 are typically reported with an E/M service. Codes 90471 and 90472 are typically reported with the E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   90471: nonfacility Family Medicine (35.3%); for all sites Family Medicine (35.3%)
   90472: nonfacility Family Medicine (41.8%); for all sites Family Medicine (41.8%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   We are recommending a net decrease of $0.76 for the Immunization Administration (IA) code family:
   Current inputs for family = $35.49
   Recommended inputs for family = $34.73
   Net decrease = $0.76

   Please note that this calculation includes the current projected inputs ($3.98) for code 90461 based upon the current CMS crosswalk for this code. Code 90461 should not have any direct PE inputs and, therefore, negligible PE RVUs (due entirely to indirect PE). This is due to the fact that 90461 represents the physician/QHP counseling (ie, work only) required for each additional component in a multicomponent vaccine.

   However, based on the fact that the IA family has been hard-coded since its inception, CMS has assigned it PE RVUs equivalent with 90472 (0.21). Therefore, we have replicated the current direct PE inputs for code 90472 for code 90461. [PLEASE SEE PINK COLUMN IN PE SPREADSHEET.]

In light of the above, we are technically not required to offer PE compelling evidence arguments. However, we provide the following information in support of our direct PE input recommendations.

Flawed Methodology

Since the Immunization Administration (IA) codes' inception, the Centers for Medicare and Medicaid Services (CMS) has valued them by hard-coding them to 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) (formerly code 90772 and then code 90782), rather than by utilizing RUC-recommendations to establish their values. CMS' decision to hard-code the base IA codes (90460, 90471, 90473) to 96372 and then value the add-on IA codes (90461, 90472, 90474) at approximately half of the base IA codes was flawed. This is illustrated by the fact 90461 is currently valued the same as 90472 and 90474, even though 90461 does contain any direct PE inputs. Code 90461 only reflects the physician/QHP work of vaccine counseling on each additional vaccine component.

Change in Clinical Staff Immunization Protocols

Immunization confirmation protocols have changed since the Immunization Administration codes were last valued due to the explosion in the number of new vaccines introduced since 2009. For example, there are 15 difference influenza vaccine presentations available today. This perhaps explains why 20% of all vaccine error reports have to do with influenza vaccine.

While electronic health records (EHRs) offer vaccine clinical decision support to predict (although not 100% accurately) the antigens required, they do not give decision support on the brand and presentation of a vaccine. Physicians/QHPs typically give orders for the antigen (eg, DTaP), but not the particular brand and presentation (eg, Daptacel, Infanrix, Kinrix, Pediarix, Pentacel, or Quadracel). Determining which of these vaccine products to use is a clinical staff decision, based on the patient's age and vaccination history.

This is further complicated by the fact that combination vaccines may only be used in some instances (eg, Kinrix (DTaP-IPV) can be given to patients who need both DTaP and IPV, but only if the patient is between ages 4-6, has had four prior doses of DTaP, and at least two prior doses of IPV). Additionally, some vaccines have different dosing requirements based on age (Hep A, Hep B, influenza), while others are the same regardless of patient age.

Finally, while the Advisory Committee on Immunization Practices (ACIP) recommends that a vaccine series be completed with the same brand whenever possible, in some cases it is acceptable to use the alternative brand in stock if the original brand is not known (DTaP), while, in other cases, using only the brand from the original dose is acceptable (MenB).

Change in ACIP Immunization Monitoring Time Recommendations (CA022)

The Advisory Committee on Immunization Practices (ACIP) recommends that "vaccine providers, particularly when vaccinating adolescents, should consider observing patients (with patients seated or lying down) for 15 minutes after vaccination to decrease the risk for injury should they faint" (please see https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf (page 71)). The ACIP recommendation has become more specific (in terms of time, description of patients who are at-risk for syncope, and position) since the IA codes were last valued.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Use of Total Clinical Staff Time in Calculating Equipment Usage
In February 2008, the RUC established a precedent for the Immunization Administration codes in that it recommended the total vaccine clinical staff time as the time of refrigerator/freezer use, rather than just the intra-service clinical staff time used in CMS' PE methodology. Our use of total clinical staff time to establish equipment recommendations accounts for a portion of the increase in the aggregate cost of direct PE inputs for the Immunization Administration codes.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We allocated 0 minutes to obtain vital signs and, therefore, are requesting no CST.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

CA007: Confirming vaccine order/checking appropriateness for patient
CA008: Checking historical and current temperatures for vaccine refrigerator; recording temperatures; reporting temperatures; vaccine inventorying; ordering vaccines; completing required Vaccines for Children (VFC) paperwork; receiving vaccines; inspecting/logging vaccines and putting them in the vaccine refrigerator; creating lot numbers in EHR

   b. Service period (includes pre, intra and post):

CA011: Giving Vaccine Information Sheet (VIS) to patient/family; getting informed consent and signature if applicable
CA014: Going to laboratory and taking vaccine vials out of vaccine refrigerator; drawing up vaccine into syringe; going back to patient room and preparing patient/parent, confirming that this is correct patient-correct vaccine
CA021: Actual administration of vaccine; bandage application
CA022: Watching patient after vaccine is administered
CA024: Disposal of vaccine-specific medical waste
CA034: Charting administered immunizations in the patient chart and EMR; preparing patient record/immunization card

   c. Post-service period:

CA037: Contacting patient/parent to follow up on immunization administration

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

CA021: RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, selects and prepares the injection site, administers the vaccine, and applies a bandage to the injection site. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
No, we are not recommending a PE supply pack.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) (NEW, line 113)

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):
    10 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

    N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    Formula: Default
    Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043)
    Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43)

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    Please note under Medical Equipment:
    Line 111 (ED043): While its description begins with "refrigerator, vaccine," it is the **temperature monitor with alarm** for the vaccine medical grade refrigerator (NEW, line 113). **We do not have two vaccine refrigerators included as part of our recommended medical equipment.**

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 90473, 90474
SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, ANA, AAP
PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Korinne Van Keuren, DNP; Elisabeth Volpert, DNP; Steven Krug, MD; Suzanne Berman, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	XXX
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
90473	A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intranasal administration of seasonal influenza vaccine.
90474	After a patient receives an intramuscular vaccine (reported separately), she receives an additional vaccine administered intranasally. (Note: This is an add-on code for the additional physician or other qualified health care professional work related to the administration of one additional vaccine (single or combination vaccine/toxoid). The physician or other qualified health care professional work for the administration of the first vaccine (single or combination vaccine/toxoid) is reported separately with code 90473.)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We convened a Practice Expense (PE) Expert Panel consisting of 15 individuals representing AAFP (RUC Advisor and Alternate RUC Advisor), ACOG (RUC Advisor), ANA (Alternate RUC/HCPAC Advisor and PE Subcommittee member), and AAP (RUC Advisor and members of the AAP Section on Administration & Practice Management and the AAP Pediatric Practice Management Alliance). After an initial virtual kick-off meeting, we surveyed Panel members on typical clinical activities, medical supplies, and medical equipment utilized in the service of immunization administration (IA). Survey results were compiled and shared via email, allowing Panel members to reach consensus on direct PE input recommendations for the IA codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   90473 and 90474 are existing codes; therefore, we are using their current direct PE inputs as their reference codes. However, we are also offering COVID IA code 0031A as a reference code. While administration of the COVID-19 vaccine is unique, the fact that the RUC recently reviewed seven (7) new COVID IA codes imparts relevance on the inclusion of 0031A as a reference for the IA codes.

SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, ANA, AAP
PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Korinne Van Keuren, DNP; Elisabeth Volpert, DNP; Steven Krug, MD; Suzanne Berman, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

NOTE: Please see attached document "90471-4 Current Direct PE Inputs" for information on how the current direct PE inputs for codes 90473 and 90474 were established.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Codes 90473 and 90474 are typically reported with an E/M service. Codes 90473 and 90474 are typically reported with the E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   90473: nonfacility General Practice (33.3%); for all sites General Practice (33.3%)
   90474: nonfacility Family Medicine (100%); for all sites Family Medicine (100%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   We are recommending a net decrease of $0.76 for the Immunization Administration (IA) code family:
   Current inputs for family = $35.49
   Recommended inputs for family = $34.73
   Net decrease = $0.76

   Please note that this calculation includes the current projected inputs ($3.98) for code 90461 based upon the current CMS crosswalk for this code. Code 90461 should not have any direct PE inputs and, therefore, negligible PE RVUs (due entirely to indirect PE). This is due to the fact that 90461 represents the physician/QHP counseling (ie, work only) required for each additional component in a multicomponent vaccine.

   However, based on the fact that the IA family has been hard-coded since its inception, CMS has assigned it PE RVUs equivalent with 90472 (0.21). Therefore, we have replicated the current direct PE inputs for code 90472 for code 90461. [PLEASE SEE PINK COLUMN IN PE SPREADSHEET.]

In light of the above, we are technically not required to offer PE compelling evidence arguments. However, we provide the following information in support of our direct PE input recommendations.

Flawed Methodology

Since the Immunization Administration (IA) codes' inception, the Centers for Medicare and Medicaid Services (CMS) has valued them by hard-coding them to 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) (formerly code 90772 and then code 90782), rather than by utilizing RUC-recommendations to establish their values. CMS' decision to hard-code the base IA codes (90460, 90471, 90473) to 96372 and then value the add-on IA codes (90461, 90472, 90474) at approximately half of the base IA codes was flawed. This is illustrated by the fact 90461 is currently valued the same as 90472 and 90474, even though 90461 does contain any direct PE inputs. Code 90461 only reflects the physician/QHP work of vaccine counseling on each additional vaccine component.

Change in Clinical Staff Immunization Protocols

Immunization confirmation protocols have changed since the Immunization Administration codes were last valued due to the explosion in the number of new vaccines introduced since 2009. For example, there are 15 difference influenza vaccine presentations available today. This perhaps explains why 20% of all vaccine error reports have to do with influenza vaccine.

While electronic health records (EHRs) offer vaccine clinical decision support to predict (although not 100% accurately) the antigens required, they do not give decision support on the brand and presentation of a vaccine. Physicians/QHPs typically give orders for the antigen (eg, DTaP), but not the particular brand and presentation (eg, Daptacel, Infanrix, Kinrix, Pediarix, Pentacel, or Quadracel). Determining which of these vaccine products to use is a clinical staff decision, based on the patient's age and vaccination history.

This is further complicated by the fact that combination vaccines may only be used in some instances (eg, Kinrix (DTaP-IPV) can be given to patients who need both DTaP and IPV, but only if the patient is between ages 4-6, has had four prior doses of DTaP, and at least two prior doses of IPV). Additionally, some vaccines have different dosing requirements based on age (Hep A, Hep B, influenza), while others are the same regardless of patient age.

Finally, while the Advisory Committee on Immunization Practices (ACIP) recommends that a vaccine series be completed with the same brand whenever possible, in some cases it is acceptable to use the alternative brand in stock if the original brand is not known (DTaP), while, in other cases, using only the brand from the original dose is acceptable (MenB).

Change in ACIP Immunization Monitoring Time Recommendations (CA022)

The Advisory Committee on Immunization Practices (ACIP) recommends that "vaccine providers, particularly when vaccinating adolescents, should consider observing patients (with patients seated or lying down) for 15 minutes after vaccination to decrease the risk for injury should they faint" (please see https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf (page 71)). The ACIP recommendation has become more specific (in terms of time, description of patients who are at-risk for syncope, and position) since the IA codes were last valued.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

Use of Total Clinical Staff Time in Calculating Equipment Usage
In February 2008, the RUC established a precedent for the Immunization Administration codes in that it recommended the total vaccine clinical staff time as the time of refrigerator/freezer use, rather than just the intra-service clinical staff time used in CMS' PE methodology. Our use of total clinical staff time to establish equipment recommendations accounts for a portion of the increase in the aggregate cost of direct PE inputs for the Immunization Administration codes.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

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9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

CA007: Confirming vaccine order/checking appropriateness for patient
CA008: Checking historical and current temperatures for vaccine refrigerator; recording temperatures; reporting temperatures; vaccine inventorying; ordering vaccines; completing required Vaccines for Children (VFC) paperwork; receiving vaccines; inspecting/logging vaccines and putting them in the vaccine refrigerator; creating lot numbers in EHR

   b. Service period (includes pre, intra and post):

CA011: Giving Vaccine Information Sheet (VIS) to patient/family; getting informed consent and signature if applicable
CA014: Going to laboratory and taking vaccine vials out of vaccine refrigerator; preparing vaccine; going back to patient room and preparing patient/parent, confirming that this is correct patient-correct vaccine
CA021: Actual administration of vaccine
CA022: Watching patient after vaccine is administered
CA024: Disposal of vaccine-specific medical waste
CA034: Charting administered immunizations in the patient chart and EMR; preparing patient record/immunization card

   c. Post-service period:

CA037: Contacting patient/parent to follow up on immunization administration

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

CA021: RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, and administers the vaccine. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
No, we are not recommending a PE supply pack.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) (NEW, line 113)

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):
    10 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

    N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    Formula: Default
    Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043)
    Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43)

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    Please note under Medical Equipment:
    Line 111 (ED043): While its description begins with "refrigerator, vaccine," it is the **temperature monitor with alarm** for the vaccine medical grade refrigerator (NEW, line 113). **We do not have two vaccine refrigerators included as part of our recommended medical equipment.**

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SoR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**0031A**		**90460**		**90460**	
3		***RUC Collaboration Website***				Immunization administration by intramuscular injection of severe acute respiratory syndrome		Immunization administration through 18 years of age via any route of administration, with counseling by		Immunization administration through 18 years of age via any route of administration, with	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 0.75**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**37.0**	**0.0**	**18.0**	**0.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**4.0**	**0.0**	**1.0**	**0.0**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**30.0**	**0.0**	**16.0**	**0.0**	**17.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**0.0**	**1.0**	**0.0**	**1.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D			1					
16	CA002		L037D								
17	CA003		L037D								
18	CA004		L037D								
19	CA005		L037D			2					
20	CA006		L037D								
21	CA007		L037D					1		1	
22	CA008		L037D			1				1	
27		**End: When patient enters office/facility for surgery/procedure**									
28		**SERVICE PERIOD**									
29		**Start: When patient enters office/facility for surgery/procedure:**									
30		**Pre-Service (of service period)**									
31	CA009		L037D			3		1			
32	CA010		L037D								
33	CA011		L037D			3		3		3	
34	CA012		L037D			1					
35	CA013		L037D			2					
36	CA014		L037D							2	
37	CA015		L037D								
38	CA016		L037D								
39	CA017		L037D								
40			L037D								
43	OLD	*Review charts*	L037D								
46		**Intra-service (of service period)**									
47	CA018		L037D								
48	CA019		L037D								
49	CA020		L037D								
50	CA021		L037D			4		4		4	
53			L037D								
54			L037D								
57		**Post-Service (of service period)**									
58	CA022		L037D			4				4	
59	CA023		L037D								
60	CA024		L037D			3		1		1	
61	CA025		L037D								
62	CA026		L037D								
63	CA027		L037D								
64	CA028		L037D								
65	CA029		L037D								
66	CA030		L037D								
67	CA031		L037D								
68	CA032		L037D								
69	CA033		L026A			7		3			
70	CA034		L037D			3		4		3	
71	CA035		L037D								
72	CA036		L037D			**n/a**		**n/a**		**n/a**	
73			L037D								
76	OLD	*Vaccine registry input/Refrigerator/freezer temperature log*	L037D								
77			L037D								
78		*Other activity: please include short clinical description here and type new in*	L037D								
79		**End: Patient leaves office/facility**									
80		**POST-SERVICE PERIOD**									
81		**Start: Patient leaves office/facility**									
82	CA037		L037D			3		1		1	
83	CA038		L037D								
84		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
85		99211 16 minutes	16								
86		99212 27 minutes	27								
87		99213 36 minutes	36								
88		99214 53 minutes	53								
89		99215 63 minutes	63								
90	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
91			L037D								
94		*Other activity: please include short clinical description here and type new in*	L037D								
97		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**0031A**		**90460**		**90460**	
3		***RUC Collaboration Website***				Immunization administration by intramuscular injection of severe acute respiratory syndrome		Immunization administration through 18 years of age via any route of administration, with counseling by		Immunization administration through 18 years of age via any route of administration, with	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 0.75**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**37.0**	**0.0**	**18.0**	**0.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**4.0**	**0.0**	**1.0**	**0.0**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**30.0**	**0.0**	**16.0**	**0.0**	**17.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**0.0**	**1.0**	**0.0**	**1.0**	**0.0**
98	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
99		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
100	SC058							1		1	
101	SJ053							2			
102	SB022					1		0.5			
103	SG021					1		1		1	
104	SK012							1		1	
105	SK057					3					
106	SB036										
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
109	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 0.75**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
111	ED043					37		16		20	
112	EF040							16			
113	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door	7674.43	Default	0.020365838	37				20	
114	EF023										
115											
116											
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	M	N	O	P	Q	R	S	T
1	RUC Practice Expense Spreadsheet		CURRENT PROJECTED INPUTS Based on current CMS crosswalk		RECOMMENDED		CURRENT		RECOMMENDED	
2			90461		90461		90471		90471	
3		*RUC Collaboration Website*	Immunization administration through 18 years of age via any route of administration, with		Immunization administration through 18 years of age via any route of administration, with		Immunization administration (includes percutaneous, intradermal,		Immunization administration (includes percutaneous, intradermal,	
4	Clinical Activity Code	Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP								
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ		ZZZ		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.41	$ -
8		TOTAL CLINICAL STAFF TIME	8.0	0.0	0.0	0.0	17.0	3.0	20.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	8.0	0.0	0.0	0.0	17.0	0.0	17.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	3.0	1.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13		PRE-SERVICE PERIOD								
14		Start: Following visit when decision for surgery/procedure made								
15	CA001									
16	CA002									
17	CA003									
18	CA004									
19	CA005									
20	CA006									
21	CA007								1	
22	CA008								1	
27		End: When patient enters office/facility for surgery/procedure								
28		SERVICE PERIOD								
29		Start: When patient enters office/facility for surgery/procedure:								
30		Pre-Service (of service period)								
31	CA009									
32	CA010									
33	CA011		3				3		3	
34	CA012									
35	CA013									
36	CA014								2	
37	CA015									
38	CA016									
39	CA017									
40										
43	OLD	*Review charts*					1			
46		Intra-service (of service period)								
47	CA018									
48	CA019									
49	CA020									
50	CA021		2				2		4	
53										
54										
57		Post-Service (of service period)								
58	CA022						3		4	
59	CA023									
60	CA024						1		1	
61	CA025									
62	CA026									
63	CA027									
64	CA028									
65	CA029									
66	CA030									
67	CA031									
68	CA032									
69	CA033									
70	CA034		2				2		3	
71	CA035						1			
72	CA036		n/a		n/a		n/a		n/a	
73										
76	OLD	*Vaccine registry input/Refrigerator/freezer temperature log*	1				4			
77										
78		*Other activity: please include short clinical description here and type new in*								
79		End: Patient leaves office/facility								
80		POST-SERVICE PERIOD								
81		Start: Patient leaves office/facility								
82	CA037							3	1	
83	CA038									
84		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
85		99211 16 minutes								
86		99212 27 minutes								
87		99213 36 minutes								
88		99214 53 minutes								
89		99215 63 minutes								
90	CA039		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
91										
94		*Other activity: please include short clinical description here and type new in*								
97		End: with last office visit before end of global period								

	A	B	M	N	O	P	Q	R	S	T
1	RUC Practice Expense Spreadsheet		CURRENT PROJECTED INPUTS Based on current CMS crosswalk		RECOMMENDED		CURRENT		RECOMMENDED	
2			90461		90461		90471		90471	
3		***RUC Collaboration Website***	Immunization		Immunization		Immunization		Immunization	
4	Clinical Activity Code	Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP	administration through 18 years of age via any route of administration, with		administration through 18 years of age via any route of administration, with		administration (includes percutaneous, intradermal,		administration (includes percutaneous, intradermal,	
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ		ZZZ		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.41	$ -
8		TOTAL CLINICAL STAFF TIME	8.0	0.0	0.0	0.0	17.0	3.0	20.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	8.0	0.0	0.0	0.0	17.0	0.0	17.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	3.0	1.0	0.0
98	Supply Code	MEDICAL SUPPLIES								
99		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
100	SC058		1				1		1	
101	SJ053		2				2			
102	SB022						1			
103	SG021		1				1		1	
104	SK012		1				1		1	
105	SK057									
106	SB036						7			
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
109	Equipment Code	EQUIPMENT								
110		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.41	$ -
111	ED043		8				17		20	
112	EF040		8				17			
113	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door							20	
114	EF023		7				13			
115										
116										
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	U	V	W	X	Y	Z	AA	AB	AC	AD
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**90472**		**90472**		**90473**		**90473**		**90474**	
3		***RUC Collaboration Website***	Immunization		Immunization		Immunization		Immunization		Immunization	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: Immunization Administration** **Specialties: AAFP, ACOG, ACP, ANA, AAP**	administration (includes percutaneous, intradermal,		administration (includes percutaneous, intradermal,		administration by intranasal or oral route; 1 vaccine (single or combination		administration by intranasal or oral route; 1 vaccine (single or combination		administration by intranasal or oral route; each additional vaccine (single or	
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**		**ZZZ**		**XXX**		**XXX**		**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**0.0**	**11.0**	**0.0**	**24.0**	**0.0**	**20.0**	**0.0**	**7.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**2.0**	**0.0**	**1.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**8.0**	**0.0**	**9.0**	**0.0**	**23.0**	**0.0**	**17.0**	**0.0**	**7.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005											
20	CA006											
21	CA007				1		1		1			
22	CA008				1				1			
27		**End: When patient enters office/facility for surgery/procedure**										
28		**SERVICE PERIOD**										
29		**Start: When patient enters office/facility for surgery/procedure:**										
30		**Pre-Service (of service period)**										
31	CA009											
32	CA010											
33	CA011		3		3		7		3		2	
34	CA012											
35	CA013											
36	CA014								2			
37	CA015											
38	CA016											
39	CA017											
40												
43	OLD	*Review charts*										
46		**Intra-service (of service period)**										
47	CA018											
48	CA019											
49	CA020											
50	CA021		2		4		5		4		4	
53												
54												
57		**Post-Service (of service period)**										
58	CA022						5		4			
59	CA023											
60	CA024								1			
61	CA025											
62	CA026											
63	CA027											
64	CA028											
65	CA029											
66	CA030											
67	CA031											
68	CA032											
69	CA033											
70	CA034		2		2		2		3			
71	CA035											
72	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
73												
76	OLD	*Vaccine registry input/Refrigerator/freezer temperature log*	1				4				1	
77												
78		*Other activity: please include short clinical description here and type new in*										
79		**End: Patient leaves office/facility**										
80		**POST-SERVICE PERIOD**										
81		**Start: Patient leaves office/facility**										
82	CA037								1			
83	CA038											
84		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
85		99211 16 minutes										
86		99212 27 minutes										
87		99213 36 minutes										
88		99214 53 minutes										
89		99215 63 minutes										
90	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
91												
94		*Other activity: please include short clinical description here and type new in*										
97		**End: with last office visit before end of global period**										

	A	B	U	V	W	X	Y	Z	AA	AB	AC	AD
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT	
2			90472		90472		90473		90473		90474	
3		***RUC Collaboration Website***	Immunization administration (includes percutaneous, intradermal,		Immunization administration (includes percutaneous, intradermal,		Immunization administration by intranasal or oral route; 1 vaccine (single or combination		Immunization administration by intranasal or oral route; 1 vaccine (single or combination		Immunization administration by intranasal or oral route; each additional vaccine (single or	
4	Clinical Activity Code	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: Immunization Administration** **Specialties: AAFP, ACOG, ACP, ANA, AAP**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**		**ZZZ**		**XXX**		**XXX**		**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**0.0**	**11.0**	**0.0**	**24.0**	**0.0**	**20.0**	**0.0**	**7.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**2.0**	**0.0**	**1.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**8.0**	**0.0**	**9.0**	**0.0**	**23.0**	**0.0**	**17.0**	**0.0**	**7.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**0.0**	**0.0**
98	**Supply Code**	**MEDICAL SUPPLIES**										
99		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
100	SC058		1		1							
101	SJ053		2				2				2	
102	SB022						1					
103	SG021		1		1							
104	SK012		1		1		1		1		1	
105	SK057											
106	SB036						7					
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
109	**Equipment Code**	**EQUIPMENT**										
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**
111	ED043		8		11		17		20		8	
112	EF040		8				17				8	
113	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door			11				20			
114	EF023		7									
115												
116												
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT CMS Crosswalk**		**RECOMMENDED**		**CURRENT CMS Crosswalk**		**RECOMMENDED**	
2			**90474**		**G0008**		**G0008**		**G0009**		**G0009**	
3		***RUC Collaboration Website***	Immunization administration by intranasal or oral route; each additional vaccine (single or		Administration of influenza virus vaccine		Administration of influenza virus vaccine		Administration of pneumococcal vaccine		Administration of pneumococcal vaccine	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: Immunization Administration** **Specialties: AAFP, ACOG, ACP, ANA, AAP**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**		**XXX**		**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**11.0**	**0.0**	**17.0**	**3.0**	**20.0**	**0.0**	**17.0**	**3.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**2.0**	**0.0**	**0.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**9.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**3.0**	**1.0**	**0.0**	**0.0**	**3.0**	**1.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005											
20	CA006											
21	CA007		1				1				1	
22	CA008		1				1				1	
27		**End: When patient enters office/facility for surgery/procedure**										
28		**SERVICE PERIOD**										
29		**Start: When patient enters office/facility for surgery/procedure:**										
30		**Pre-Service (of service period)**										
31	CA009											
32	CA010											
33	CA011		3		3		3		3		3	
34	CA012											
35	CA013											
36	CA014						2				2	
37	CA015											
38	CA016											
39	CA017											
40												
43	OLD	*Review charts*			1				1			
46		**Intra-service (of service period)**										
47	CA018											
48	CA019											
49	CA020											
50	CA021		4		2		4		2		4	
53												
54												
57		**Post-Service (of service period)**										
58	CA022				3		4		3		4	
59	CA023											
60	CA024				1		1		1		1	
61	CA025											
62	CA026											
63	CA027											
64	CA028											
65	CA029											
66	CA030											
67	CA031											
68	CA032											
69	CA033											
70	CA034		2		2		3		2		3	
71	CA035				1				1			
72	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
73												
76	OLD	*Vaccine registry input/Refrigerator/freezer temperature log*			4				4			
77												
78		*Other activity: please include short clinical description here and type new in*										
79		**End: Patient leaves office/facility**										
80		**POST-SERVICE PERIOD**										
81		**Start: Patient leaves office/facility**										
82	CA037					3	1			3	1	
83	CA038											
84		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
85		99211 16 minutes										
86		99212 27 minutes										
87		99213 36 minutes										
88		99214 53 minutes										
89		99215 63 minutes										
90	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
91												
94		*Other activity: please include short clinical description here and type new in*										
97		**End: with last office visit before end of global period**										

	A	B	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT CMS Crosswalk**		**RECOMMENDED**		**CURRENT CMS Crosswalk**		**RECOMMENDED**	
2			**90474**		**G0008**		**G0008**		**G0009**		**G0009**	
3		***RUC Collaboration Website***	Immunization administration by intranasal or oral route; each additional vaccine (single or		Administration of influenza virus vaccine		Administration of influenza virus vaccine		Administration of pneumococcal vaccine		Administration of pneumococcal vaccine	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: Immunization Administration** **Specialties: AAFP, ACOG, ACP, ANA, AAP**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**		**XXX**		**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**11.0**	**0.0**	**17.0**	**3.0**	**20.0**	**0.0**	**17.0**	**3.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**2.0**	**0.0**	**0.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**9.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**	**17.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**3.0**	**1.0**	**0.0**	**0.0**	**3.0**	**1.0**	**0.0**
98	**Supply Code**	**MEDICAL SUPPLIES**										
99		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
100	SC058				1		1		1		1	
101	SJ053				2				2			
102	SB022				1				1			
103	SG021				1		1		1		1	
104	SK012		1		1		1		1		1	
105	SK057											
106	SB036				7				7			
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
109	**Equipment Code**	**EQUIPMENT**										
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 0.22**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**	**$ -**	**$ -**	**$ 0.41**	**$ -**
111	ED043		11		17		20		17		20	
112	EF040				17				17			
113	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door	11				20				20	
114	EF023				13				13			
115												
116												
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AO	AP	AQ	AR
1	RUC Practice Expense Spreadsheet		CURRENT CMS Crosswalk		RECOMMENDED	
2			G0010		G0010	
3		***RUC Collaboration Website***	Administration of hepatitis b vaccine		Administration of hepatitis b vaccine	
4	Clinical Activity Code	Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP				
5		LOCATION	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ 0.41	$ -
8		TOTAL CLINICAL STAFF TIME	17.0	3.0	20.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	17.0	0.0	17.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	1.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -
13		PRE-SERVICE PERIOD				
14		Start: Following visit when decision for surgery/procedure made				
15	CA001					
16	CA002					
17	CA003					
18	CA004					
19	CA005					
20	CA006					
21	CA007				1	
22	CA008				1	
27		End: When patient enters office/facility for surgery/procedure				
28		SERVICE PERIOD				
29		Start: When patient enters office/facility for surgery/procedure:				
30		Pre-Service (of service period)				
31	CA009					
32	CA010					
33	CA011		3		3	
34	CA012					
35	CA013					
36	CA014				2	
37	CA015					
38	CA016					
39	CA017					
40						
43	OLD	*Review charts*	1			
46		Intra-service (of service period)				
47	CA018					
48	CA019					
49	CA020					
50	CA021		2		4	
53						
54						
57		Post-Service (of service period)				
58	CA022		3		4	
59	CA023					
60	CA024		1		1	
61	CA025					
62	CA026					
63	CA027					
64	CA028					
65	CA029					
66	CA030					
67	CA031					
68	CA032					
69	CA033					
70	CA034		2		3	
71	CA035		1			
72	CA036		n/a		n/a	
73						
76	OLD	*Vaccine registry input/Refrigerator/freezer temperature log*	4			
77						
78		*Other activity: please include short clinical description here and type new in*				
79		End: Patient leaves office/facility				
80		POST-SERVICE PERIOD				
81		Start: Patient leaves office/facility				
82	CA037			3	1	
83	CA038					
84		***Office visits: List Number and Level of Office Visits***	# visits	# visits	# visits	# visits
85		99211 16 minutes				
86		99212 27 minutes				
87		99213 36 minutes				
88		99214 53 minutes				
89		99215 63 minutes				
90	CA039		0.0	0.0	0.0	0.0
91						
94		*Other activity: please include short clinical description here and type new in*				
97		End: with last office visit before end of global period				

	A	B	AO	AP	AQ	AR
1	RUC Practice Expense Spreadsheet		CURRENT CMS Crosswalk		RECOMMENDED	
2			G0010		G0010	
3		***RUC Collaboration Website***	Administration of hepatitis b vaccine		Administration of hepatitis b vaccine	
4	Clinical Activity Code	Meeting Date: April 2021 Revision Date (if applicable): Tab: Immunization Administration Specialties: AAFP, ACOG, ACP, ANA, AAP				
5		LOCATION	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ 0.41	$ -
8		TOTAL CLINICAL STAFF TIME	17.0	3.0	20.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	17.0	0.0	17.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	1.0	0.0
98	Supply Code	MEDICAL SUPPLIES				
99		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -
100	SC058		1		1	
101	SJ053		2			
102	SB022		1			
103	SG021		1		1	
104	SK012		1		1	
105	SK057					
106	SB036		7			
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*				
109	Equipment Code	EQUIPMENT				
110		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ 0.41	$ -
111	ED043		17		20	
112	EF040		17			
113	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door			20	
114	EF023		13			
115						
116						
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*				

Immunization Administration (IA)
90471-90474
Source of Current Direct PE Inputs

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473 Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Clinical Activities (CA)

	February 2000 PEAC	February 2001 RUC	March 2002 RUC	February 2008 RUC (Incremental)	Current
90471	**20 minutes (Nonfacility) (NF)** 10 minutes Review patient chart; obtain informed consent; educate patient regarding possible side effects; record vaccine information (lot number, manufacturer, VIS information) 5 minutes Draw up serum; administer vaccine 5 minutes Monitor patient for adverse reaction; educate patient regarding follow-up		**13 minutes (Nonfacility) (NF)** 1 minute Review charts 3 minutes F/u on physician's discussion with patient/parent & obtain actual consent signature 2 minutes Draw up serum; administer vaccine 3 minutes Monitor patient following service 1 minute Clean room/equipment by physician staff 1 minute Home care instructions 2 minutes Record vaccine information (lot number, manufacturer, VIS information) **3 minutes (Facility) (F)** 3 minutes F/u to ensure that patient's medical record reflects immunizations given, thereby ensuring continuity of care in the medical home	**4 minutes NF***	**13 + 4 = 17 minutes NF** **3 minutes F**
90472	**6 minutes (Nonfacility (NF)** 2 minutes Obtain informed consent for each vaccine; record vaccine information (lot number, manufacturer, VIS information) 4 minutes Draw up serum; administer vaccine		**7 minutes (Nonfacility) (NF)** 3 minutes F/u on physician's discussion with patient/parent & obtain actual consent signature 2 minutes Draw up serum; administer vaccine	**1 minute NF***	**7 + 1 = 8 minutes NF**

			2 minutes Record vaccine information (lot number, manufacturer, VIS information)		
90473		**20 minutes (Nonfacility) (NF)** 10 minutes Review patient chart; obtain informed consent; educate patient regarding possible side effects; record vaccine information (lot number, manufacturer, VIS information) 5 minutes Draw up serum; administer vaccine 5 minutes Monitor patient for adverse reaction; educate patient regarding follow-up		**4 minutes NF***	**20 + 4 = 24 minutes NF**
90474		**6 minutes (Nonfacility (NF)** 2 minutes Obtain informed consent for each vaccine; record vaccine information (lot number, manufacturer, VIS information) 4 minutes Draw up serum; administer vaccine		**1 minute NF***	**6 + 1 = 7 minutes NF**

***February 2008 RUC Other Clinical Activity: Vaccine registry input/Refrigerator/freezer temperature log monitoring/documentation [2 times per day] [Logs kept for 3 years]/Refrigerator/freezer alarm monitoring/documentation**

Medical Supplies (Nonfacility (NF) Only)

	February 2000 PEAC	**February 2001 RUC**	**March 2002 RUC**	**February 2008 RUC (Incremental)**	**Current**
90471	SB036 paper, exam table (7) SK012 CDC information sheet (1) SB022 gloves, non-sterile (1 pair) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)		SB036 paper, exam table (7) SK012 CDC information sheet (1) SB022 gloves, non-sterile (1 pair) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)		SB036 paper, exam table (7) SK012 CDC information sheet (1) SB022 gloves, non-sterile (1 pair) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)
90472	SK012 CDC information sheet (1) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)		SK012 CDC information sheet (1) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)		SK012 CDC information sheet (1) SJ053 swab-pad, alcohol (2) SG021 bandage, strip 0.75in x 3in (Bandaid) (1) SC058 syringe w-needle, OSHA compliant (SafetyGlide) (1)

90473		SB036 paper, exam table (7) SK012 CDC information sheet (1) SB022 gloves, non-sterile (1 pair) SJ053 swab-pad, alcohol (2)			SB036 paper, exam table (7) SK012 CDC information sheet (1) SB022 gloves, non-sterile (1 pair) SJ053 swab-pad, alcohol (2)
90474		SK012 CDC information sheet (1) SJ053 swab-pad, alcohol (2)			SK012 CDC information sheet (1) SJ053 swab-pad, alcohol (2)

Medical Equipment (Nonfacility (NF) Only)

	February 2000 PEAC	February 2001 RUC	March 2002 RUC	February 2008 (Incremental)	Current
90471			**13 minutes** EF023 table, exam	**17 minutes**** EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	**13 minutes exam table** **17 minutes fridge** **17 minutes fridge monitor/alarm**
90472			**7 minutes** EF023 table, exam	**8 minutes**** EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	**7 minutes exam table** **8 minutes fridge** **8 minutes fridge monitor/alarm**
90473				**17 minutes**** EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	**17 minutes fridge** **17 minutes fridge monitor/alarm**
90474				**8 minutes**** EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	**8 minutes fridge** **8 minutes fridge monitor/alarm**

****February 2008 RUC recommended, and CMS accepted, use of total vaccine clinical staff time as the time of refrigerator/freezer use, rather than just the intra-service clinical staff time as typically used in CMS' PE methodology.**

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization over 30,000*

April 2021

Dark Adaption Eye Exam – Tab 20

In July 2020, the Relativity Assessment Workgroup identified one CPT code 92284 *Dark adaptation examination with interpretation and report* with 2019e Medicare utilization over 30,000. The Workgroup requested that the specialty societies submit an action plan addressing CPT code 92284 for January 2021. In January 2021, the RUC agreed with the specialty society that this service be surveyed for the April 2021 RUC meeting. The RUC noted that the family of services should be identified on the level of interest (LOI). The specialty societies indicated that there are no additional codes in this family. CPT 92284 is in a section of CPT labeled "Other Specialized Services" which contains several unrelated services performed using different techniques with different and unrelated physician work.

92284 ***Dark adaptation examination with interpretation and report***
The RUC reviewed the survey results from 45 ophthalmologists, retina specialists and optometrists for CPT code 92284 and determined that a direct work RVU crosswalk to CPT code 76514 *Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)* (work RVU = 0.14, 5 minutes of total time) appropriately accounts for the work required to perform this service. The RUC recommends 1 minute of pre-service time, 3 minutes of intra-service time, 1 minute of immediate post-service time, totaling 5 minutes for CPT code 92284. The specialty societies agreed that the recommended physician work and total time is more representative of the physician or other qualified healthcare professional (QHP) work associated with this procedure than the survey 25th percentile work RVU value of 0.45. The specialty society also noted that the recommended reduction in total time (from the current 36 minutes of total time) is due in part to the fact that CPT code 92284 is typically performed on the same date of an office or eye visit service.

The RUC discussed that CPT code 92284 is a diagnostic service but noted the manufacturer of the device used to perform this service markets the new model of this device to be used for both screening and diagnosis. The specialty societies confirmed that the work associated with CPT code 92284 is diagnostic in nature and that CPT code 92284 was not intended to be utilized for screening services. The specialty societies explained that intra-service work associated with CPT code 92284 involves physician or QHP interpretation and analysis of a machine generated data display to make a differential diagnosis. **The RUC recommends that CPT code 92284 be referred to CPT to editorially revise and include the word "diagnostic' in the code descriptor**.

The RUC compared CPT code 92284 to MPC code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 6 minutes of total time) and discussed the similarity in the type of work with respect to interpretation and reporting while also noting the more complex nature of ECG interpretation which justifies a slightly higher work RVU value and 1 minute of additional total time. The RUC noted that both services would appropriately have an identical work per unit time of 0.028. The RUC also compared CPT code 92284 to CPT code 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17, 6 minutes of total time). **The RUC recommends a work RVU of 0.14 for CPT code 92284.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC to ensure correct valuation and utilization assumptions. The RUC will review the typical technology used to perform this service when it is next re-evaluated, acknowledging that the device included in proposed direct practice costs recently was very recently replaced with a newer technology.

Practice Expense
The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification and noted that the recommended reduction in practice expense inputs represents a greater than 50 percent decrease in direct practice expense costs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

RUC Referral to CPT
The RUC recommends CPT code 92284 be referred to CPT to editorially revise and include the word "diagnostic' in the code descriptor. "<u>Diagnostic</u> dark adaptation examination with interpretation and report."

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
92284	Dark adaptation examination with interpretation and report	XXX	0.14

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92284 Tracking Number Original Specialty Recommended RVU: **0.24**
Presented Recommended RVU: **0.17**
Global Period: XXX Current Work RVU: **0.24** RUC Recommended RVU: **0.14**

CPT Descriptor: Dark adaptation examination with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female with poor night vision has no identifiable cause on examination. Dark adaptation testing is performed to assess retinal function.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Explain the indications, risks, benefits, and nature of the dark adaptation test to the patient and/or family. Determine the appropriate testing strategy and place an order in the electronic health record.

Description of Intra-Service Work: Review the test results for each eye to determine reliability and interocular consistency. Interpret results, correlating the dark adaptation plot with age-adjusted norms, physical findings, and prior test results. Prepare a report and enter it into the medical record.

Description of Post-Service Work: Sign the report. Enter the findings in the electronic health record and send a letter to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); John T. Thompson, MD (ASRS); Charles Fitzpatrick, OD (AOA)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO), American Society of Retina Specialists (ASRS); American Optometric Association (AOA)					
CPT Code:	92284					
Sample Size:	3069	**Resp N:**	45			
Description of Sample:	Random sample of US practicing members of AAO, ASRS, and AOA					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	11.25	1000.00
Survey RVW:	0.15	0.45	**0.50**	0.60	1.25
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	92284	**Recommended Physician Work RVU: 0.14**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**3.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**1.00**	**0.00**	**1.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92083	XXX	0.50	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92134	XXX	0.45	**RUC Time**

CPT Descriptor Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	18,866,949

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73120	XXX	0.16	**RUC Time**	278,753

CPT Descriptor 2 Radiologic examination, hand; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
93000	XXX	0.17	**RUC Time**

CPT Descriptor Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 48.8 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 92284	Top Key Reference CPT Code: 92083	2nd Key Reference CPT Code: 92134
Median Pre-Service Time	1.00	3.00	1.00
Median Intra-Service Time	4.00	10.00	10.00
Median Immediate Post-service Time	1.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**6.00**	**13.00**	**11.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	45%	32%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	27%	32%	41%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	50%	32%

Physical effort required	18%	68%	14%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	55%	27%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	25%	25%	50%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	38%	25%	38%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	13%	38%	50%
Physical effort required	13%	50%	38%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	75%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 92284, *Dark adaptation examination with interpretation and report* is an XXX-global code that was identified as Harvard-valued with utilization over 30,000. The test is performed on patients with visual loss, typically poor night vision, and no identifiable cause on physical examination. Newer test protocols and machines have been introduced since the test

was first valued, and the patient population has expanded to include those with macular degeneration, resulting in increasing claims volume. The test has moved from being largely a research tool in academic medical centers to widespread clinical use.

Although CPT 92284 is in a section of CPT labeled "Other Specialized Services," it is not part of a family with any of the other 8 codes in that section (CPT 92265, 92270, 92273, 92274, 92283, 92285, 92286, and 92287). "Other Specialized Services" is a category for a diverse array of ophthalmic tests that do not fit elsewhere in CPT. They range from tests that measure muscle and retinal electrical responses, to subjective tests of color vision, and to imaging of different parts of the eye using different imaging techniques for management of different diseases by different subspecialists.

For CPT 92284, a dark adaptation test protocol is selected by the physician or other qualified health professional which is tailored to the patient's symptoms and findings. The new equipment used to administer the test is typically a desktop model that was introduced a few years ago. An even newer head-worn model offering greater convenience has recently been introduced. Marketing for this new model highlights a screening protocol that is not typical and that reports a single number indicating whether the test is normal or abnormal. For the diagnostic test in patients with nyctalopia or complaints of poor night vision, which is typical, a dark adaptation plot of sensitivity vs. time for each eye is interpreted by correlating to age-adjusted norms, physical findings, comorbidities known to affect night vision (e.g., vitamin deficiencies, cataracts, presence of treatments such as panretinal photocoagulation), and, if available, prior test results. Findings are entered into the medical record and a report is generated.

It remains to be determined whether the newest equipment and the shorter testing protocol are clinically useful or achieve sufficient market penetration to become typical. The technology remains in a state of flux. For that reason, this procedure should be placed on the New Technology list.

The procedure is typically performed on the same day as an office visit.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO), American Optometric Association (AOA), and American Society of Retinal Specialists (ASRS) members. There were 45 responses. The vignette was considered typical by 80% of respondents. The median WRVU was 0.50, and the 25th percentile was 0.45. The current value of the code is 0.24 WRVU. The survey median IST was 15 minutes, pre-service evaluation time was 5 minutes, and immediate post-service time was 10 minutes. The current (Harvard) IST and total time are 36 minutes.

The top key reference service, chosen by 49% of respondents, was CPT 92083, *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (RUC 2012), with a WRVU of 0.50, an IST of 10 minutes, and a total time of 13 minutes. The second reference service, chosen by 18% of respondents, was CPT 92134, *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina* (RUC 2015), with a WRVU of 0.45, an IST of 10 minutes, and total time of 11 minutes. A plurality or majority of the respondents ranked the surveyed code identical to the top key reference service on overall intensity and complexity and each of the submeasures. Half of the respondents ranked the surveyed code higher than the second reference service on the overall intensity and complexity measure and on the technical skill submeasure. The ranking of the remaining submeasures was distributed evenly.

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The median intraservice time of 15 minutes is significantly shorter than the current IST, but longer than expected for interpretation of test results. This IST would correlate to the physician participating in the administration of the test in addition to interpreting the results.

The panel therefore analyzed the survey data by specialty to determine if there was a specialty-specific difference. The panel noted that 64% of respondents were MDs, while 80% of claims are from ODs. The median performance rate was low (2), with a significant number of respondents who reported a zero-performance rate (21/45, 47%). We therefore also analyzed the data by performers vs. non-performers. The subgroup data are listed in separate rows of the revised Summary Spreadsheet. There were no remarkable differences in IST or WRVU estimates between the overall result and any of the subgroups.

The panel's expectation that a technician would administer the test appeared inconsistent with the survey data, which suggested that the provider administered the test. We therefore queried the 45 respondents, asking them to answer the following question: "When performing the test, who typically (over 50% of the time) acquires the data? You or a technician/staff member?" We received 29 responses, with 23 (79%) stating that a technician or staff member acquires the data and 6 (21%) stating that the provider acquires the data. We also analyzed these responses by provider type and performers vs. non-performers.

Data Acquisition	All (n=29)	MD (n=16)	OD (n=13)	Performers (n=18)	Non Performers (n=11)
Tech/Staff	23	15	8	13	10
Provider	6	1	5	5	1

In all groups, staff acquisition of data was typical. Based on this response, the panel rejected the survey IST and chose an IST consistent with the amount of time required for the provider to analyze the validity of the test by evaluating fixation losses and then interpret the plots of retinal sensitivity over time for the two eyes: 4 minutes.

Because the procedure is typically performed on the same day as an office visit, we reduced the pre-time from the survey value of 5 minutes to 1 minute. This time is required to explain the test to the patient and enter an order into the EHR. The testing device is not integrated with the EHR. We reduced the survey post-time from 10 minutes to 1 minute, which is necessary to sign the report, enter the results into the EHR, and send a letter to the referring physician. The total time for the procedure is 6 minutes, with a 4-minute IST.

The survey 25th percentile work value estimate of 0.45 is greater than the code's current value. Although there have been technological advances in the instrumentation used to perform the test and the patient population has expanded to include patients with macular degeneration, we were unable to find compelling evidence that this increased the physician work of the procedure. The physician work remains unchanged for the typical case with the legacy machine currently in use in the typical practice.

After discussion following pre-facilitation, we further considered the impact of the introduction of the newest instrument, which generates an automated report. It can be used to screen patients without nyctalopia or macular degeneration as well as performing diagnostic testing with a plot of sensitivity over time. We chose to value the code for patients with an existing diagnosis as a test in which a physician interprets a machine-generated data display and prepares a report as the typical service in 2021.

A similar procedure in which a physician interprets a machine-generated report is MPC code 93010, *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (RUC 2019). This code has a work value of 0.17 RVU, a 3-minute IST (1 minute shorter than our recommendation), and 6 minutes of total time (identical to our recommendation). We chose this code as a crosswalk and **therefore recommend a work value for CPT 92284 of 0.17 WRVU.**

This value is also supported by CPT 93000, Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (RUC 2019), with 0.17 WRVU and pre/intra/post times of 2/3/1, and a total time of 6 minutes.

This is as accurate a representation of the physician work as it currently stands as we can recommend with the data we have in light of the evolving nature of the technology. Because of that evolving technology, we recommend that this code be placed on the New Technology list for review in 3 years.

We recommend a work value for CPT 92284 of 0.17 WRVU with times of 1/4/1, a total time of 6 minutes, and a crosswalk to CPT 93010.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Typically reported with an office visit.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global Period	Work RVU	Pre	Intra	Post	% Billed Together
4.	92250	XXX	0.40	1	10	1	34.8%
5.	92014	XXX	1.42	5	24	8	30.1%
6.	92134	XXX	0.45	1	10		26.7%
7.	92083	XXX	0.50	3	10		24.7%
8.	99213	XXX	1.30	5	20	5	13.6%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92284

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 20000 Percentage 20.00 %

Specialty Optometry Frequency 80000 Percentage 80.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 55,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on recent annual growth in RUC DB claims.

Specialty Ophthalmology Frequency 11000 Percentage 20.00 %

Specialty Optometry Frequency 44000 Percentage 80.00 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92284

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT, Work Per Unit Time and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE:

TAB:

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF						#DIV/0!	#DIV/0!						0																									
2nd REF						#DIV/0!	#DIV/0!						0																									
CURRENT						#DIV/0!	#DIV/0!						0																									
SVY						#DIV/0!	#DIV/0!						0																									
REC						#DIV/0!	#DIV/0!						0																									

SS Rec Summary

ISSUE: Dark Adaptation Eye Exam (CPT 92284)

TAB: 20

source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	92083	XXX	Visual field ex	2012	22	0.043	0.038			0.50			13	3					10																				
2nd REF	92134	XXX	Scanning com	2015	8	0.043	0.041			0.45			11	1					10																				
CURRENT	92284	XXX	Dark adaptatio	N/A - Harvard		0.007	0.007			0.24			36						36																				
SVY	92284	XXX	Dark adaptation		45	0.011	0.017	0.15	0.45	0.50	0.60	1.25	30	5			1	10	15	20	60	10													0	0	2	11	1000
SVY - MD	92284	XXX	Dark adaptation		29	0.009	0.016	0.15	0.48	0.50	0.60	1.25	31	6			1	6	15	20	60	10													0	0	0	2	20
SVY - OD	92284	XXX	Dark adaptation		16	0.011	0.017	0.27	0.44	0.50	0.61	1.00	30	5			2	10	15	19	30	10													0	5	18	101	1000
SVY - PERFORMERS	92284	XXX	Dark adaptation examination with		24	0.011	0.017	0.27	0.49	0.50	0.63	1.25	30	5			2	6	15	20	60	10													1	5	10	21	1000
SVY - NON-PERFORMERS	92284	XXX	Dark adaptation examination with		21	0.011	0.017	0.15	0.45	0.50	0.55	0.80	30	6			1	10	15	20	60	9													0	0	0	0	0
SVY - EXCLUDE PERFORMERS > 1000	92284	XXX	Dark adaptation examination with interpretation and report		44	0.010	0.016	0.15	0.47	0.50	0.61	1.25	30.5	5.5			1	10	15	20	60	10													0	0	1	10	200
REC	92284	XXX	Dark adaptation examination with interpretation and report			0.032	0.028			0.14			5	1					3			1																
XWALK	76514	XXX	Ophthalmic ultrasound,	2017		0.032	0.028			0.14			5	1					3			1																

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_92284_**
SPECIALTY SOCIETY(IES):_AAO, AOA, ASRS__
PRESENTER(S):_ David Glasser, Ankoor Shah, Charlie Fitzpatrick, Harvey Richman, John Thompson_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
92284	Dark adaptation examination with interpretation and report	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
92284	A 55 year old female with poor night vision has no identifiable cause on examination. Dark adaptation is performed to assess retinal function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other healthcare providers who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The healthcare providers on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Yes.
   Yes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Optometry (80%)
   Non-facility Performance (100%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

Standard times were used with care to eliminate duplication given the same day office visit. Granular detail is provided below. Standard input times used for pre, intra, and post activities. **Pre:** (Standard Inputs) Line CA011 – The technician provides education and obtains consent for the procedure. Line CA013 – The technician prepares the room, equipment, and supplies. Line CA016 – The patient is positioned, occlude is patched over the fellow eye. **Intra:** Line CA021 – The time listed includes time to occlude the non-tested eye, place trial lenses in front of the eye being tested as well as run the actual test on the dark adaptation device. The same procedure is repeated for the fellow eye. The technician is in the room the whole time providing real time coaching/feedback as the test is performed. **Post:** (Standard Inputs) Line CA024 – The technician will clean the room and pack up the equipment utilized. Line CA031 – The technician will review with the healthcare provider the patient's performance on the activities, before the provider comes up with a finalize plan.

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

During the intra-service period the technician will start by placing a series of trial lenses over the tested eye to account for their optimal prescription. This can often include multiple lenses with trial

and error to determine the optimal lenses. Next the patient's head is placed into the tabletop device and the test is run. During the test the technician remains in the room with the patient 100% of the time and provides real time feedback/coaching as the test is performed.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    No.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    Supplies:
    Line SG043 Dressing, eye pad – Added - used to cover the fellow eye during testing
    Line SJ053 Swab-pad, alcohol – Was omitted in error, but is utilized to sterilize equipment prior to patient use.

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    Invoices will be provided for new supplies with standard/default formulas.

Dark Adaptometer – device used to bleach and subsequently test the ability of the patient to dark adapt.

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

5 years

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment.

EQ029 – Humphrey field analyzer – Removed – no longer used.
EL006 – lane, screening (oph) – Removed from Initial Recommendation – this test is now typically performed in a screening lane, trial lenses are included in this lane which are necessary for performing this test.
EQ165 – lens set, trial – Added - utilized to place appropriate prescription before testing is performed.
EF030 – table, motorized – Added - utilized to raise/lower the dark adaptometer device

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

The updates reflect the change to a different dark adaptometer which is now more typical. The current form of the device that is typical is the tabletop version (AdaptDx). We anticipate this to remain the typical version for this test for the next several years despite a newer version that became available in 2020 but at a significantly higher cost.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org

immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	G	H	I	J
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**	
2						**CPT Code 92284**		**CPT Code 92284**	
3		***RUC Collaboration Website***				Dark adaptation examination with interpretation and report		Dark adaptation examination with interpretation and report	
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 20 Specialty: AAO, AOA, ASRS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ 2.78**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A			**69.0**	**0.0**	**26.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A			**8.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A			**61.0**	**0.0**	**26.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A			**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001		L038A			5			
16	CA002		L038A						
17	CA003		L038A						
18	CA004		L038A						
19	CA005		L038A			3			
20	CA006		L038A						
21	CA007		L038A						
22	CA008		L038A						
23			L038A						
26		*Other activity: please include short clinical description here and type*	L038A						
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009		L038A			3			
34	CA010		L038A						
35	CA011		L038A			3		2	
36	CA012		L038A			2			
37	CA013		L038A			2		2	
38	CA014		L038A					1	
39	CA015		L038A						
40	CA016		L038A					1	
41	CA017		L038A						
42			L038A						
45		*Other activity: please include short clinical description here and type*	L038A						
48		**Intra-service (of service period)**							
49	CA018		L038A			45			
50	CA019		L038A						
51	CA020		L038A						
52	CA021		L038A					15	
55			L038A						
56		*Other activity: please include short clinical description here and type*	L038A						
59		**Post-Service (of service period)**							
60	CA022		L038A						
61	CA023		L038A						
62	CA024		L038A			3		3	
63	CA025		L038A						
64	CA026		L038A						
65	CA027		L038A						
66	CA028		L038A						
67	CA029		L038A						
68	CA030		L038A						
69	CA031		L038A			3		2	
70	CA032		L038A						
71	CA033		L038A						
72	CA034		L038A						
73	CA035		L038A						
74	CA036		L038A			**n/a**		**n/a**	
75			L038A						
78		*Other activity: please include short clinical description here and type*	L038A						
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037		L038A						
85	CA038		L038A						
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16						
88		99212 27 minutes	27						
89		99213 36 minutes	36						
90		99214 53 minutes	53						
91		99215 63 minutes	63						
92	CA039		L038A			**0.0**	**0.0**	**0.0**	**0.0**
93			L038A						
96		*Other activity: please include short clinical description here and type*	L038A						
99		**End: with last office visit before end of global period**							

	A	B	D	E	F	G	H	I	J
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2						**CPT Code 92284**		**CPT Code 92284**	
3		***RUC Collaboration Website***				Dark adaptation examination with interpretation and report		Dark adaptation examination with interpretation and report	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 20** **Specialty: AAO, AOA, ASRS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ 2.78**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A			**69.0**	**0.0**	**26.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A			**8.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A			**61.0**	**0.0**	**26.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A			**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**
102	SJ053							2	
103	SG043							1	
104									
105									
106									
107									
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ 2.78**	**$ -**
112	EQ029			Default		61		0	
113	EL006			Default				0	
114	EQ165			Default				24	
115	EF030			Default				24	
116									
117	**NEW**	*Dark Adaptometer*	29925.00	Default	0.115963181			24	

April 24, 2021

Zach Hochstetler
Director, CPT Editorial Panel
American Medical Association
AMA Plaza
330 N. Wabash Ave, Suite 39300
Chicago, IL 60611-5885

Dear Mr. Hochstetler,

As a result of the April 2021 RUC meeting, it is now necessary to revise the descriptor for CPT 92284. The discussion at the RUC concluded to have a CPT editorial revision that specifies 92284 as a diagnostic code. As a result, the American Academy of Ophthalmology, the American Society of Retina Specialists, and the American Optometric Association propose the following editorial revision:

▲ 92284 Diagnostic dark adaptation examination with interpretation and report

If there are additional questions or comments regarding this revision, please contact Kayla L. Amodeo, AAO Director of Health Policy, via email at kamodeo@aao.org.

Sincerely,



Michael X. Repka, MD, MBA
AAO Medical Director for Government Affairs

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CPT Assistant Analysis

April 2021

Anterior Segment Imaging – Tab 21

In 2011, CPT code 92286 was originally identified via the *Harvard Valued – Medicare Utilization over 30,000* screen and code 92287 was added as part of the family for review. The American Academy of Ophthalmology (AAO) indicated that apart from utilizing an image, codes 92286 and 92287 have completely different clinical indications and conditions. CPT code 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow-up care of post corneal transplant patients. The specialty societies believed that coding education and publication of a CPT Assistant article may help clarify the difference between codes 92287 and 92235. The RUC recommended that the specialty society develop a CPT Assistant article to clarify the difference between CPT codes 92287 and 92235.

In October 2018, the Relativity Assessment Workgroup reviewed a list of RUC referrals for CPT Assistant articles from 2013-2016. The Workgroup requested action plans for January 2019. In January 2019, the RUC recommended to review this service in two years to determine if the article and CPT changes were effective. In December 2020, the specialty societies noted that the CPT Assistant article addressed concerns with the appropriate reporting of macular degeneration. Medicare claims data for 2018 indicated that there is no confusion between 92287, 92286 or 92132. The diagnoses associated with claims for CPT 92287 do not include the glaucoma, cornea, or lens diagnoses which would be associated with CPT 92286 or 92132. However, the specialty societies noted that this service is Harvard valued and would benefit to be surveyed to include a vignette, description of work, updated physician time and valuation. A Workgroup member also commented that 92287 is frequently reported with fluorescein angiography of retina (92235). The RUC recommended that CPT code 92287 be surveyed for the April 2021 RUC meeting. The specialty societies indicated that despite its appearance as a "child" code of 92286, these are two wholly unrelated services in terms of instrumentation, diagnoses, and physician work.

92287 ***Anterior segment imaging with interpretation and report; with fluorescein angiography***
The RUC reviewed the survey results from 30 ophthalmologists and retina specialists for CPT code 92287 and determined that a direct work RVU crosswalk to MPC code 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes of intra-service and 12 minutes total time) appropriately accounts for the work required to perform this service. The RUC recommends 1 minute of pre-service time, 10 minutes of intra-service time, and 1 minute of immediate post-service time. The RUC noted that 92287 is performed with an office or eye visit 95 percent of the time. The RUC ensured that its work and time recommendations represent work that is distinct and separate from the same-day office or eye visit services.

The RUC noted that both CPT code 92287 and CPT code 92250 are performed on both eyes and that the 1 minute of pre-service time is associated with entry of patient data into the electronic health record. The RUC also noted that the recommendation to decrease the valuation of 92287 reflects the marginal decrease in time.

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The RUC compared CPT code 92287 to CPT code 92201 *Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral* (work RVU = 0.40, 10 minutes of intra-service and 12 minutes of total time) determined that both services require nearly identical physician work, time and intensity, which supports the RUC recommended work RVU valuation of 92287. The RUC also compared CPT code 92287 to MPC code 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU = 0.40, 8 minutes of intra-service and 11 minutes of total time). The RUC concluded that CPT code 92287 should be valued based on a direct work RVU crosswalk to MPC code 92250. **The RUC recommends a work RVU of 0.40 for CPT code 92287**.

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

Practice Expense
The Practice Expense (PE) Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. The RUC discussed whether a butterfly needle (SC030) and Bandaid (SG021) are included in this procedure even though this is often performed with retinal fluorescein angiography. The specialty societies clarified that it is typical to remove the butterfly needle and bandage the arm after the initial push rather than attempting to reuse the needle. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	XXX	0.40

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92287 Tracking Number Original Specialty Recommended RVU: **0.40**
Presented Recommended RVU: **0.40**
Global Period: XXX Current Work RVU: **0.81** RUC Recommended RVU: **0.40**

CPT Descriptor: Anterior segment imaging with interpretation and report; with fluorescein angiography

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old diabetic male has possible iris neovascularization. Fluorescein angiography is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Explain the indications, risks, and benefits of iris angiography to the patient and/or family. Enter order into the electronic health record.

Description of Intra-Service Work: The quality of the study is evaluated. The fluorescein angiogram images from both eyes are compared and interpreted. Findings are compared with previous studies and other diagnostic modalities and a diagnosis is determined. The results are reviewed and discussed with the patient. Representative images are selected for archiving for future comparison. A report is prepared and dictated for entry into the medical record. The referring physician is informed of the results.

Description of Post-Service Work: The report is signed. Findings are included in a letter that accompanies the report and is sent to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Ankoor R. Shah, MD (AAO); David B. Glasser, MD (AAO); John T. Thompson, MD (ASRS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO), American Society of Retina Specialists (ASRS)					
CPT Code:	92287					
Sample Size:	2075	**Resp N:**	30			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO and AOA					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**5.00**	9.00	500.00	
Survey RVW:	0.40	0.70	**0.75**	0.80	1.20	
Pre-Service Evaluation Time:			**5.50**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	6.00	**10.00**	15.00	25.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	92287	**Recommended Physician Work RVU: 0.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**1.00**	**0.00**	**1.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92235	XXX	0.75	**RUC Time**

CPT Descriptor Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92240	XXX	0.80	**RUC Time**

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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.40	**RUC Time**	3,490,129

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92082	XXX	0.40	**RUC Time**	122,984

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

Other Reference CPT Code	Global	Work RVU	Time Source
92201	XXX	0.40	**RUC Time**

CPT Descriptor Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 60.0 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 92287	Top Key Reference CPT Code: 92235	2nd Key Reference CPT Code: 92240
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	10.00	15.00	20.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**12.00**	**17.00**	**22.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	56%	28%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	39%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	61%	33%
Physical effort required	0%	89%	11%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	61%	39%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	100%	0%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	80%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	100%	0%
Physical effort required	0%	100%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	80%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 92287, *Anterior segment imaging with interpretation and report; with fluorescein angiography,* is a Harvard-valued code in a section of CPT labeled "Other Specialized Services" containing a number of unrelated diagnostic testing services. It was originally, and incorrectly, identified as in a family with CPT 92286, *Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis,* because of its location in CPT following the listing for

CPT 92286. This child code shared only the CPT hierarchy of location of the imaging and not the same technology or set of indications or use.

CPT 92287 is performed for evaluation of patients for iris neovascularization (rubeosis iridis) due to diabetes, retinal vascular occlusion, or ocular ischemic syndrome. It involves intravenous injection of fluorescein dye and imaging of the iris and is typically performed by a retina or ocular oncology subspecialist. In contrast, CPT 92286 is performed for determination of corneal endothelial cell density in patients with corneal endothelial dystrophy, corneal edema, or cataract to assess endothelial function prior to surgery. It involves a photograph of the cornea with no use of dye and is typically performed by a cornea subspecialist. The procedures themselves, the data and images generated, the interpretation processes, the diagnoses for which they are performed, the subspecialists that typically perform them, and the physician work are all unrelated.

Similarly, CPT 92287 is not in a family with any of the other ophthalmic angiography services (CPT 92230, 92235, 92240, 92242) listed under the "Ophthalmoscopy" heading in CPT. It is segregated under the "Other Specialized Services" heading because it images the iris for diagnosis of iris neovascularization, while the others image the retina for diagnosis and management of a variety of unrelated retinal diseases. Thus many of the differences which distinguish CPT 92287 from 92286 also apply to CPT 92230-92242: the data, images, interpretation processes, and diagnoses are all unrelated.

CPT 92287 is now being reviewed as a Harvard-valued code with modestly increasing claims volume (from 4,117 in 2016 to 7,182 in 2019). The procedure is typically performed on the same day as an office visit. Fluorescein angiography of the retina (CPT 92235) and fundus photography (CPT 92250) are also typically performed on the same day because the most common use of CPT 92287 is in the setting of diabetic eye disease which affects both posterior and anterior segments of the eye.

A survey was sent to a random selection of American Academy of Ophthalmology (AAO) and American Society of Retinal Specialists (ASRS) members. There were 30 responses. The vignette was considered typical by 93% of respondents. The median WRVU was 0.75, and the 25th percentile was 0.70. The current value of the code is 0.81 WRVU. The survey median IST was 10 minutes, pre-service evaluation time was 6 minutes, and immediate post-service time was 10 minutes. The current (Harvard) IST and total time are 23 minutes.

The top key reference service, chosen by 60% of respondents, was CPT 92235, *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (RUC 2016), with 0.75 WRVU, an IST of 15 minutes, and a total time of 17 minutes. The second reference service, chosen by 17% of respondents, was CPT 92240, *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (RUC 2016), with a WRVU of 0.80, an IST of 20 minutes, and total time of 22 minutes. Most respondents ranked the surveyed code identical to both reference services on overall intensity and complexity and each of the submeasures.

The expert panel, which is familiar with the procedure and the RUC process, reviewed the survey findings. The median intraservice time of 10 minutes was accepted as appropriate for the number of images and amount of data to analyze and interpret. Because the procedure is typically performed on the same day as an office visit, we reduced the pre-time from the survey value of 6 minutes to 1 minutes. We reduced the survey post-time from 10 minutes to 1 minutes. The total time for the procedure is 12 minutes, with a 10-minute IST.

The survey 25th percentile work value estimate of 0.70 appeared high in comparison to the key reference services which have similar work values and lower ISTs given the identical intensity and complexity rankings. **We recommend instead a work value of 0.40 WRVU** with a crosswalk to MPC code 92250, *Fundus photography with interpretation and report* (RUC 2016). The crosswalk code has 0.40 WRVU, an identical IST of 10 minutes, and an identical total time of 12 minutes. Although equal to the survey low estimate, this is an accurate representation of the physician work associated with CPT 92287. While IWPUTs are often unreliable for short services, the IWPUT at this value (0.036) is similar to that of both reference services which were ranked identical on the intensity/complexity measures.

The recommended value is also supported by CPT 92201, *Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral* (RUC 2018), with 0.40 WRU and an identical IST (10 minutes) and total time (12 minutes).

Based on a crosswalk to MPC code 92250, we recommend a work value for CPT 92287 of 0.40 RVU with times of 1/10/1 and a total time of 12 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Typically performed with an office visit and retinal imaging.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Global Period	Work RVU	Pre	Intra	Post	% Billed Together
4.	92235	XXX	0.75	1	15	1	86.7%
5.	92250	XXX	0.40	1	10	1	67.8%
6.	92014	XXX	1.42	5	24	8	55.4%
7.	92226	XXX	0.81		23		43.3%
8.	92134	XXX	0.45	1	10		32.8%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92287

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on Medicare claims.

Specialty Ophthalmology Frequency 14000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 RUC DB claims volume adjusted for recent growth.

Specialty Ophthalmology Frequency 8500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Other

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92287

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT, Work Per Unit Time and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE:

TAB:

									RVW						PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF						#DIV/0!	#DIV/0!						0																										
2nd REF						#DIV/0!	#DIV/0!						0																										
CURRENT						#DIV/0!	#DIV/0!						0																										
SVY						#DIV/0!	#DIV/0!						0																										
REC						#DIV/0!	#DIV/0!						0																										

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AI	AJ	AK	AL	AM	AR	AS	AT	AU	AV
3	**ISSUE:** Anterior Segment Imaging																																							
4	**TAB:** 21																																							
5					RUC			Work Per	RVW					Total	PRE			INTRA					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
6	source	CPT	Global	DESC	Review Year	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
7	1st REF	92235	XXX	Fluorescein angiography (includes mu	2016	18	0.047	0.044			0.75			17	1					15			1																	
8	2nd REF	92240	XXX	Indocyanine-green angiography (inclu	2016	5	0.038	0.036			0.80			22	1					20			1																	
9	CURRENT	92287	XXX	Anterior segment imaging with interpr	N/A - Harvard		0.035	0.035			0.81			23						23																				
10	SVY	92287	XXX	Anterior segment imaging with interpretation and report; with		30	0.039	0.029	0.40	0.70	0.75	0.80	1.20	26	6			1	6	10	15	25	10													0	2	5	9	500
11	REC	92287	XXX	Anterior segment imaging with interpretation and report; with fluorescein angiography			0.036	0.033			0.40			12	1					10			1																	
12	XWALK	92250	XXX	Fundus photography with interpretation and report	2016		0.036	0.033			0.40			12	1					10			1																	

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_92287_**
SPECIALTY SOCIETY(IES):_AAO, ASRS__
PRESENTER(S):_ David Glasser, Ankoor Shah, John Thompson_

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
92287	A 67 year old diabetic male has possible iris neovascularization. Fluorescein angiography is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other healthcare providers who have the appropriate expertise as needed. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The healthcare providers on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The current code was used as a reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Yes.
   Yes.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Ophthalmology (100%)
   Non-facility Performance (100%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

Standard times were used with care to eliminate duplication given the same day office visit. Granular detail is provided below. Standard input times used for pre, intra, and post activities. Su **Pre:** (Standard Inputs) Line CA011 (Line 37)– The technician provides education and obtains consent for the procedure. The input has been changed from RN to CRA (lowering cost) to reflect how the test is typically performed. Line CA013 – The CRA prepares the room, equipment, and supplies. Line CA016 – The CRA cleans the arm and connects a butterfly needle for IV push of the fluorescein dye. **Intra:** Line CA021 – The CRA injects the dye and begins taking pictures. Several pictures are taken of each eye at early and late phases which conveys different information about the iris vasculature. **Post:** (Standard Inputs) Line CA024 – The CRA will clean the room and pack up the equipment utilized. Line CA031 – The CRA will review with the healthcare provider the patient's performance on the activities, before the provider comes up with a finalize plan.

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

The CRA will inject the fluorescein dye into the patients vein. The patient will then undergo a series of photos taken at different time intervals for each eye. A number of early and late photos are taken to visualize the iris vasculature. Throughout the test the CRA will reassess and reposition the patient as needed to obtain adequate photos.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    No.

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Supplies:
Line SA050 pack, ophthalmology - *Removed*
Line SJ043 povidone swabsticks (3 pack) - *Removed*
Line SG021 Bandages – Maintained as before – cover wound post procedure
Line SC029 needles 18-27G - *Removed*
Line SC057 syringe 5-6ml - Maintained as before – load the fluorescein dye
Line SC030 butterfly needle - Maintained as before – inject the fluorescein dye
Line SH033 fluorescein inj - Maintained as before – actual dye utilized
Line SK058 paper photo - *Removed*
Line SK030 film - *Removed*
Line SC018 IV infusion set - *Removed*

Line SB023 gloves, nonsterile – *Added* – this is added as the ophthalmology pack which had gloves was removed
Line SG008 applicator, cotton-tipped – *Added* – this is added as the ophthalmology pack which had cotton tip applicator was removed. Used to hold eyelids open while taking photos.
Line SJ041 Betadine – *Added* – this replaces the povidone swabsticks which are no longer used as typical.

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

20. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

22. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Default formulas were used for all equipment, as there is no highly technical equipment.

EL005 – lane, exam – Removed – no longer used.
EQ168 – light, exam – Added – more typical of what is used in the room photos are taken
EF030 – motorized table – Maintained – used to adjust patient height/position
EQ029 – Humphrey field analyzer – Removed – no longer used.
EF027 – table, instrument – Added – typical of the room now used, required for equipment placement
ED003 – camera – Maintained – utilized for photo acquisition.

23. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

A butterfly needle and Band-Aid are included in this procedure despite the fact that this is often performed with retinal fluorescein angiography. This is because it is typical to remove the butterfly needle and bandage the arm after the initial push, rather than attempting to reuse the needle which would likely blow the vein during the 15-20 minutes of movement while taking the photo as well as the movement to a separate camera. We accordingly have no input for an IV, tape, tegaderm, or heparin flush, etc that would be required to keep the butterfly needle patent for the 20-30 minutes of the first angiographic procedure when done on the same day as another procedure. Thus we believe there are no duplicative supplies.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	C	D	E	F
1	**RUC Practice Expense Spreadsheet**					
2						
3		***RUC Collaboration Website***				
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 21 Specialty: AAO, ASRS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**
5		**LOCATION**				
6		**GLOBAL PERIOD**				
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				
8		**TOTAL CLINICAL STAFF TIME**		L038A		
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L039A		
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L039A		
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L051A		
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L039A		
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				
14		**PRE-SERVICE PERIOD**				
15		**Start: Following visit when decision for surgery/procedure made**				
16	CA001			L039A		
17	CA002			L039A		
18	CA003			L039A		
19	CA004			L039A		
20	CA005			L039A		
21	CA006			L039A		
22	CA007			L039A		
23	CA008			L039A		
24				L039A		
27		*Other activity: please include short clinical description here and type*		L039A		
30		**End: When patient enters office/facility for surgery/procedure**				
31		**SERVICE PERIOD**				
32		**Start: When patient enters office/facility for surgery/procedure:**				
33		**Pre-Service (of service period)**				
34	CA009			L039A		
35	CA010			L039A		
36	CA011			L051A		
37	CA011			L039A		
38	CA012			L039A		
39	CA013			L039A		
40	CA014			L039A		
41	CA015			L039A		
42	CA016			L051A		
43	CA016			L039A		
44	CA017			L039A		
45				L039A		
48		*Other activity: please include short clinical description here and type*		L039A		
51		**Intra-service (of service period)**				
52	CA018			L039A		
53	CA019			L039A		
54	CA020			L039A		
55	CA021			L039A		
58				L039A		
59		*Other activity: please include short clinical description here and type*		L039A		
62		**Post-Service (of service period)**				
63	CA022			L039A		
64	CA023			L039A		
65	CA024			L039A		
66	CA025			L039A		
67	CA026			L039A		
68	CA027			L039A		
69	CA028			L039A		
70	CA029			L039A		
71	CA030			L039A		
72	CA031			L039A		
73	CA032			L039A		
74	CA033			L039A		
75	CA034			L039A		
76	CA035			L039A		
77	CA036			L039A		
78				L039A		
81		*Label & file photos/slides*		L039A		
84		**End: Patient leaves office/facility**				
85		**POST-SERVICE PERIOD**				
86		**Start: Patient leaves office/facility**				
87	CA037			L038A		
88	CA038			L038A		
89		***Office visits: List Number and Level of Office Visits***		**MINUTES**		
90		99211 16 minutes		16		
91		99212 27 minutes		27		
92		99213 36 minutes		36		
93		99214 53 minutes		53		
94		99215 63 minutes		63		
95	CA039			L038A		
96				L038A		
99		*Other activity: please include short clinical description here and type*		L038A		
102		**End: with last office visit before end of global period**				

	A	B	C	D	E	F
1	**RUC Practice Expense Spreadsheet**					
2						
3		***RUC Collaboration Website***				
4	**Clinical Activity Code**	**Meeting Date: April 2021 Revision Date (if applicable): Tab: 21 Specialty: AAO, ASRS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**
5		**LOCATION**				
6		**GLOBAL PERIOD**				
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				
8		**TOTAL CLINICAL STAFF TIME**		L038A		
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L039A		
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L039A		
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L051A		
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L039A		
103	**Supply Code**	**MEDICAL SUPPLIES**		**PRICE**	**UNIT**	
104		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				
105	SA050					
106	SJ043					
107	SG021					
108	SC029					
109	SC057					
110	SC030					
111	SH033					
112	SK058					
113	SK030					
114	SC018					
115	SK065					
116	SB023					
117	SC027					
118	SG008					
119	SJ041					
120						
121						
122		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*	*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice in column B, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*			
124	**Equipment Code**	**EQUIPMENT**		**Purchase Price**	**Equipment Formula**	**Cost Per Minute**
125		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				
126	EL005				Default	
127	EQ168				Default	
128	EF030				Default	
129	EF027				Default	
130	ED003				Default	
131						
132						
133						
134		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*	*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice in column B, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*			

	A	B	G	H	I	J
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 92287**		**CPT Code 92287**	
3		***RUC Collaboration Website***	Anterior segment imaging with interpretation and report; with fluorescein		Anterior segment imaging with interpretation and report; with fluorescein	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 21** **Specialty: AAO, ASRS**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**81.0**	**0.0**	**30.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**69.0**	**0.0**	**30.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**7.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**
14		**PRE-SERVICE PERIOD**				
15		**Start: Following visit when decision for surgery/procedure made**				
16	CA001		5			
17	CA002					
18	CA003					
19	CA004					
20	CA005					
21	CA006					
22	CA007					
23	CA008					
24						
27		*Other activity: please include short clinical description here and type*				
30		**End: When patient enters office/facility for surgery/procedure**				
31		**SERVICE PERIOD**				
32		**Start: When patient enters office/facility for surgery/procedure:**				
33		**Pre-Service (of service period)**				
34	CA009		2			
35	CA010					
36	CA011		5			
37	CA011				1	
38	CA012		2			
39	CA013		4		2	
40	CA014					
41	CA015					
42	CA016		2			
43	CA016				2	
44	CA017					
45						
48		*Other activity: please include short clinical description here and type*				
51		**Intra-service (of service period)**				
52	CA018					
53	CA019					
54	CA020					
55	CA021		40		20	
58						
59		*Other activity: please include short clinical description here and type*				
62		**Post-Service (of service period)**				
63	CA022					
64	CA023		5			
65	CA024		3		3	
66	CA025					
67	CA026					
68	CA027					
69	CA028					
70	CA029		3			
71	CA030					
72	CA031					
73	CA032				2	
74	CA033					
75	CA034					
76	CA035		7			
77	CA036		**n/a**		**n/a**	
78						
81		*Label & file photos/slides*	3			
84		**End: Patient leaves office/facility**				
85		**POST-SERVICE PERIOD**				
86		**Start: Patient leaves office/facility**				
87	CA037					
88	CA038					
89		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**
90		99211 16 minutes				
91		99212 27 minutes				
92		99213 36 minutes				
93		99214 53 minutes				
94		99215 63 minutes				
95	CA039		**0.0**	**0.0**	**0.0**	**0.0**
96						
99		*Other activity: please include short clinical description here and type*				
102		**End: with last office visit before end of global period**				

	A	B	G	H	I	J
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 92287**		**CPT Code 92287**	
3		***RUC Collaboration Website***	Anterior segment imaging with interpretation and report; with fluorescein		Anterior segment imaging with interpretation and report; with fluorescein	
4	**Clinical Activity Code**	**Meeting Date: April 2021** **Revision Date (if applicable):** **Tab: 21** **Specialty: AAO, ASRS**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**81.0**	**0.0**	**30.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**69.0**	**0.0**	**30.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**7.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
103	**Supply Code**	**MEDICAL SUPPLIES**				
104		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**
105	SA050		1			
106	SJ043		1			
107	SG021		2		1	
108	SC029		1			
109	SC057		1		1	
110	SC030		1		1	
111	SH033		1		1	
112	SK058		2			
113	SK030		24			
114	SC018		1		0	
115	SK065		16			
116	SB023				1	
117	SC027				1	
118	SG008				2	
119	SJ041				10	
120						
121						
122		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*				
124	**Equipment Code**	**EQUIPMENT**				
125		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**
126	EL005		66			
127	EQ168				28	
128	EF030		66		28	
129	EF027				28	
130	ED003		66		28	
131						
132						
133						
134		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*				