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

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COVID-19 Immunization Administration for CPT 2021

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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 (e.g., 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.
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.

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Enclosed Recommendations and Supporting Materials:

- 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:
RUC Participants
Perry Alexion, MD
Larry Chan
Arkaprava Deb, MD
Edith Hambrick, MD
Ryan Howe
Christiane LaBonte
Scott Lawrence
Karen Nakano, MD
Michael Soracoe
Gift Tee
Emily Yoder
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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 2,641 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,582 services, redistributing $5 billion annually. Here are the outcomes for the committee’s review of 2,641 codes:

### Potentially Misvalued Services Project

- **Codes under Review, 52, 2%**
- **Deleted, 492, 19%**
- **Decreased, 1,090, 41%**
- **Increased, 321, 12%**
- **Reaffirmed, 686, 26%**

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 755 services. In September 2010, the re-review cycle began and since then the RUC has recommended 54 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 279 services every April 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 2017) 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 these recommendation for the 2021 and 2023 Medicare Physician Payment Schedules.

In 2019, the RUC lowered the threshold for site-of-service anomalies based on the review of three years of data (2016, 2017 and 2018) 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 2017-2019 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 2019 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 one service after additional utilization data is collected. The CPT Editorial Panel deleted 12 codes and the RUC submitted recommendations for 17 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 RUC removed one service from the screen. The CPT Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules and one service for the 2023 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

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 16 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 nine services for the 2021-2023 Medicare Physician Payment Schedules.

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 and expanded. Three services were removed from this screen, one was referred to the CPT Editorial Panel for revision, one was requested for CMS to delete and six 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 2018 Medicare utilization over 1,000, which was expanded to eight services to include the family of services. The RUC submitted 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 2018 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 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 14 services as part of the family. The RUC submitted recommendations for 13 services for the 2021 and 2023 Medicare Physician Payment Schedules. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate. The RUC has completed review of the services under this screen.

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.

Final Rule for 2022
In the Final Rule for 2022, CMS received public nomination on one code as potentially misvalued. The RUC reviewed and submitted a recommendation for the 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

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<tr>
<td>RUC to review future review after additional data obtained</td>
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*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.
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<th>Code</th>
<th>Description</th>
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Tuesday, February 1, 2022

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### Status Report: CMS Requests and Relativity Assessment Issues

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### Anesthesia Services for Image-Guided Spinal Procedures

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<td>01941</td>
<td>Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic</td>
<td>XXX</td>
<td>Anesthesia Services for Image-Guided Spinal Procedures</td>
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<td>Yes</td>
<td>January 2021</td>
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<td>Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral</td>
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<td>0275T</td>
<td>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</td>
<td>YYY</td>
<td>Anesthesia Services for Image-Guided Spinal Procedures</td>
<td>High Volume Category III</td>
<td>Yes</td>
<td>January 2020</td>
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<td>0376T</td>
<td>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)</td>
<td>2020</td>
<td>Cataract Removal with Drainage Device Insertion</td>
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<td>Yes</td>
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<td>0379T</td>
<td>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</td>
<td>2020</td>
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<td>High Volume Category III</td>
<td>No</td>
<td>January 2020</td>
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<td>0394T</td>
<td>High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed</td>
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## 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

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<td>Insertion/ Removal of Implantable Interstitial Glucose Sensor System</td>
<td>CMS Request - Final Rule for 2020</td>
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- **Most Recent RUC Meeting:** January 2020
- **Tab:** 33
- **Specialty Developing Recommendation:** AACE, ES
- **First Identified:** November 2019
- **Medicare Utilization:**
  - **2020:** 17

**Result:** Contractor Price

**Referred to CPT:** February 2021

**Referred to CPT Asst:**

**Published in CPT Asst:**

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

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- **Most Recent RUC Meeting:** January 2020
- **Tab:** 33
- **Specialty Developing Recommendation:** AACE, ES
- **First Identified:** November 2019
- **Medicare Utilization:**
  - **2020:** 10

**Result:** Contractor Price

**Referred to CPT:** February 2021

**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

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- **Most Recent RUC Meeting:** January 2020
- **Tab:** 33
- **Specialty Developing Recommendation:** AACE, ES
- **First Identified:** November 2019
- **Medicare Utilization:**
  - **2020:** 20

**Result:** Contractor Price

**Referred to CPT:** February 2021

**Referred to CPT Asst:**

**Published in CPT Asst:**

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- **Most Recent RUC Meeting:** October 2017
- **Tab:** 04
- **Specialty Developing Recommendation:**
- **First Identified:** June 2017
- **2020 Medicare Utilization:** 317
- **2022 Work RVU:** 0.80
- **2022 NF PE RVU:** 0.60
- **2022 Fac PE RVU:** 0.35
- **Result:** Decrease
- **Published in CPT Asst:**

| 10005| Fine needle aspiration biopsy, including ultrasound guidance; first lesion    | XXX    | Fine Needle Aspiration | CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2020 | Yes       |
|      |                                                                             |        |                        |                                                                       |           |

- **Most Recent RUC Meeting:** January 2020
- **Tab:** 21
- **Specialty Developing Recommendation:**
- **First Identified:** June 2017
- **2020 Medicare Utilization:** 118,014
- **2022 Work RVU:** 1.46
- **2022 NF PE RVU:** 2.48
- **2022 Fac PE RVU:** 0.54
- **Result:** Decrease
- **Published in CPT Asst:**

| 10006| Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion | ZZZ    | Fine Needle Aspiration | CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 | Yes       |
|      | (list separately in addition to code for primary procedure)                    |        |                        |                                                                       |           |

- **Most Recent RUC Meeting:** October 2017
- **Tab:** 04
- **Specialty Developing Recommendation:**
- **First Identified:** June 2017
- **2020 Medicare Utilization:** 27,167
- **2022 Work RVU:** 1.00
- **2022 NF PE RVU:** 0.68
- **2022 Fac PE RVU:** 0.38
- **Result:** Decrease
- **Published in CPT Asst:**
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion</th>
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<th>10008</th>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>10010</td>
<td>Fine needle aspiration biopsy, including CT guidance; each additional lesion (list separately in addition to code for primary procedure)</td>
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<td>10011</td>
<td>Fine needle aspiration biopsy, including MR guidance; first lesion</td>
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<td>10012</td>
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<td>Fine Needle Aspiration</td>
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<td>Fine Needle Aspiration</td>
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<td>Image-guided fluid collection drainage by catheter (eg, abscess, hematoma,</td>
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| 10060    | Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single | 010    | Incision and Drainage of Abscess | Harvard Valued - Utilization over 100,000                   | Yes      | 1.22           | 2.35           | 1.74           |
|          | Most Recent RUC Meeting: October 2010                                       |        |                              |                                                             |          |                |                |                |
|          | Tab: 07 Specialty Developing Recommendation: APMA                           |        |                              |                                                             |          |                |                |                |
|          | First Identified: February 2010                                             |        |                              |                                                             |          |                |                |                |
|          | 2020 Medicare Utilization: 301,942                                           |        |                              |                                                             |          |                |                |                |
|          | RUC Recommendation: 1.50                                                    |        |                              |                                                             |          |                |                |                |
|          | Referred to CPT                                                             |        |                              |                                                             |          |                |                |                |
|          | Referred to CPT Asst                                                       |        |                              |                                                             |          |                |                |                |
|          | Published in CPT Asst                                                      |        |                              |                                                             |          |                |                |                |
|          | Result: Increase                                                            |        |                              |                                                             |          |                |                |                |

| 10061    | Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple | 010    | Incision and Drainage of Abscess | Harvard Valued - Utilization over 100,000 / 010-Day Global Post-Operative Visits2 | Yes      | 2.45           | 3.55           | 2.63           |
|          | Most Recent RUC Meeting: January 2020                                       |        |                              |                                                             |          |                |                |                |
|          | Tab: 37 Specialty Developing Recommendation: APMA                           |        |                              |                                                             |          |                |                |                |
|          | First Identified: October 2009                                              |        |                              |                                                             |          |                |                |                |
|          | 2020 Medicare Utilization: 112,597                                           |        |                              |                                                             |          |                |                |                |
|          | RUC Recommendation: Maintain. 2.45                                          |        |                              |                                                             |          |                |                |                |
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|          | Referred to CPT Asst                                                       |        |                              |                                                             |          |                |                |                |
|          | Published in CPT Asst                                                      |        |                              |                                                             |          |                |                |                |
|          | Result: Maintain                                                            |        |                              |                                                             |          |                |                |                |
# Status Report: CMS Requests and Relativity Assessment Issues

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<td>CMS Request to Review Families of Recently Reviewed CPT Codes</td>
<td>Yes</td>
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<td>Tab: 30  Specialty Developing Recommendation: APMA</td>
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<td></td>
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<td>RUC Recommendation: Maintain</td>
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<td>Result: Maintain</td>
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</table>
## Status Report: CMS Requests and Relativity Assessment Issues

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

<table>
<thead>
<tr>
<th>Global: 000</th>
<th>Issue: Trim Skin Lesions</th>
</tr>
</thead>
</table>

**Screen:** MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes  
**Complete?** Yes

**2022 Work RVU:** 0.50  
**2022 NF PE RVU:** 1.93  
**2022 Fac PE RVU:** 0.11

**First Identified:** October 2010  
**Medicare Utilization:** 1,666,621

---

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

<table>
<thead>
<tr>
<th>Global: 000</th>
<th>Issue: RAW Review</th>
</tr>
</thead>
</table>

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

**2022 Work RVU:** 0.65  
**2022 NF PE RVU:** 2.01  
**2022 Fac PE RVU:** 0.14

**First Identified:** November 2011  
**Medicare Utilization:** 292,269

---

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

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue: Biopsy of Skin Lesion</th>
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**Screen:** MPC List / CMS High Expenditure Procedural Codes2  
**Complete?** Yes

**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**

**First Identified:** October 2010  
**Medicare Utilization:**  

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**RUC Recommendation:** 0.50

**Recommended:** Referred to CPT Asst  
**Published in CPT Asst:** No

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**RUC Recommendation:** Maintain

**Recommended:** Referred to CPT Asst  
**Published in CPT Asst:** No

---

**RUC Recommendation:** Deleted from CPT

**Recommended:** Referred to CPT Asst  
**Published in CPT Asst:** No

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**RUC Recommendation:**

**Recommended:**

**Published in CPT Asst:**
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Complete?</th>
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<tbody>
<tr>
<td>11101</td>
<td>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)</td>
<td></td>
<td>Biopsy of Skin Lesion</td>
<td>Low Value Billed in Multiple Units / CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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#### Detailed Information

- **Most Recent RUC Meeting**: April 2017
- **Tab**: 05
- **Specialty Developing Recommendation**: AAD
- **First Identified**: October 2010
- **2020 Medicare Utilization**: 2022 Work RVU:
  - 2022 NF PE RVU:
  - 2022 Fac PE RVU:
- **RUC Recommendation**: Deleted from CPT
- **Referred to CPT**: February 2017
- **Result**: Deleted from CPT
- **2022 Work RVU**: 0.66
- **2022 NF PE RVU**: 2.32
- **2022 Fac PE RVU**: 0.37
- **Medicare Utilization**: Decrease

---

### 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

#### Detailed Information

- **Most Recent RUC Meeting**: April 2017
- **Tab**: 05
- **Specialty Developing Recommendation**: 0.66
- **First Identified**: February 2017
- **2020 Medicare Utilization**: 2022 Work RVU:
  - 2022 NF PE RVU:
  - 2022 Fac PE RVU:
- **RUC Recommendation**: 0.66
- **Referred to CPT**: February 2017
- **Result**: Decrease
- **2022 Work RVU**: 0.66
- **2022 NF PE RVU**: 2.32
- **2022 Fac PE RVU**: 0.37
- **Medicare Utilization**: Decrease

---

### 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

#### Detailed Information

- **Most Recent RUC Meeting**: April 2017
- **Tab**: 05
- **Specialty Developing Recommendation**: 0.38
- **First Identified**: February 2017
- **2020 Medicare Utilization**: 2022 Work RVU:
  - 2022 NF PE RVU:
  - 2022 Fac PE RVU:
- **RUC Recommendation**: 0.38
- **Referred to CPT**: February 2017
- **Result**: Decrease
- **2022 Work RVU**: 0.38
- **2022 NF PE RVU**: 1.10
- **2022 Fac PE RVU**: 0.22
- **Medicare Utilization**: Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
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<th>Screen</th>
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<td>11104</td>
<td>Punch biopsy of skin (including simple closure, when performed); single lesion</td>
<td>0.83</td>
<td>Skin Biopsy</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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<td>2022 NF PE RVU: 2.87</td>
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<td></td>
<td>2022 Work RVU: 0.83</td>
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<td></td>
<td>2022 Fac PE RVU: 0.45</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>11105</td>
<td>Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (list separately in addition to code for primary procedure)</td>
<td>0.45</td>
<td>Skin Biopsy</td>
<td>CMS High Expenditure Procedural Codes2</td>
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<td>Medicare Utilization: 86,591</td>
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<td>2022 NF PE RVU: 1.27</td>
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<td></td>
<td>2022 Fac PE RVU: 0.25</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>11106</td>
<td>Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion</td>
<td>1.01</td>
<td>Skin Biopsy</td>
<td>CMS High Expenditure Procedural Codes2</td>
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<td>2022 Fac PE RVU: 0.54</td>
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## 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)

<table>
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<td>ZZZ</td>
<td>Skin Biopsy</td>
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**Most Recent RUC Meeting:** April 2017  
**Tab:** 05  
**Specialty Developing Recommendation:**

**First Identified:** February 2017  
**2020 Medicare Utilization:** 7,813

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

<table>
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<tbody>
<tr>
<td>000</td>
<td>Shaving of Epidermal or Dermal Lesions</td>
<td>CMS High Expenditure Procedural Codes1</td>
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</table>

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

**First Identified:** January 2012  
**2020 Medicare Utilization:** 82,507

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

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<td>000</td>
<td>Shaving of Epidermal or Dermal Lesions</td>
<td>CMS High Expenditure Procedural Codes1</td>
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**Most Recent RUC Meeting:** April 2012  
**Tab:** 38  
**Specialty Developing Recommendation:** AAD

**First Identified:** January 2012  
**2020 Medicare Utilization:** 175,815

**RUC Recommendation:** 0.90  
**Result:** Increase  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

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*Note: The table continues with additional entries not shown in the excerpt.*
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>Case Number</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>11302</strong> Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm</td>
<td></td>
</tr>
<tr>
<td><strong>11303</strong> Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm</td>
<td></td>
</tr>
<tr>
<td><strong>11305</strong> Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less</td>
<td></td>
</tr>
<tr>
<td><strong>11306</strong> Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm</td>
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<table>
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<th>Issue: Shaving of Epidermal or Dermal Lesions</th>
<th>Screen: CMS High Expenditure Procedural Codes1</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td><strong>11302</strong> Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm</td>
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<tr>
<td><strong>11303</strong> Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm</td>
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<tr>
<td><strong>11305</strong> Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less</td>
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<tr>
<td><strong>11306</strong> Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm</td>
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<td>RUC Code</td>
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<tr>
<td>11307</td>
<td>Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm</td>
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<tr>
<td>11308</td>
<td>Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm</td>
<td>000</td>
<td>Shaving of Epidermal or Dermal Lesions</td>
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<tr>
<td>11310</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less</td>
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<td>Shaving of Epidermal or Dermal Lesions</td>
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<tr>
<td>11311</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm</td>
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<td>Shaving of Epidermal or Dermal Lesions</td>
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</table>
### 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**  
**Most Recent RUC Meeting:** April 2012  
**Tab:** 38  
**Specialty Developing Recommendation:** AAD  
**Global:** 000  
**Issue:** Shaving of Epidermal or Dermal Lesions  
**Screen:** CMS High Expenditure Procedural Codes  
**Complete?** Yes  
**First Identified:** January 2012  
**2020 Medicare Utilization:** 37,360  
**2022 Work RVU:** 1.30  
**2022 NF PE RVU:** 3.23  
**2022 Fac PE RVU:** 0.73  
**Result:** Increase  
**RUC Recommendation:** 1.80  
**Referral to CPT**  
**Referral to CPT Asst**  
**Published in CPT Asst:**

**11313**  
**Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**  
**Most Recent RUC Meeting:** April 2012  
**Tab:** 38  
**Specialty Developing Recommendation:** AAD  
**Global:** 000  
**Issue:** Shaving of Epidermal or Dermal Lesions  
**Screen:** CMS High Expenditure Procedural Codes  
**Complete?** Yes  
**First Identified:** January 2012  
**2020 Medicare Utilization:** 6,566  
**2022 Work RVU:** 1.68  
**2022 NF PE RVU:** 3.56  
**2022 Fac PE RVU:** 0.94  
**Result:** Increase  
**RUC Recommendation:** 2.00  
**Referral to CPT**  
**Referral to CPT Asst**  
**Published in CPT Asst:**

**11719**  
**Trimming of nondystrophic nails, any number**  
**Most Recent RUC Meeting:** January 2012  
**Tab:** 32  
**Specialty Developing Recommendation:** APMA  
**Global:** 000  
**Issue:** Debridement of Nail  
**Screen:** Low Value-High Volume  
**Complete?** Yes  
**First Identified:** October 2010  
**2020 Medicare Utilization:** 618,801  
**2022 Work RVU:** 0.17  
**2022 NF PE RVU:** 0.23  
**2022 Fac PE RVU:** 0.04  
**Result:** Maintain  
**RUC Recommendation:** 0.17  
**Referral to CPT**  
**Referral to CPT Asst**  
**Published in CPT Asst:**

**11720**  
**Debridement of nail(s) by any method(s); 1 to 5**  
**Most Recent RUC Meeting:** September 2011  
**Tab:** 53  
**Specialty Developing Recommendation:** APMA  
**Global:** 000  
**Issue:** Debridement of Nail  
**Screen:** MPC List  
**Complete?** Yes  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 1,664,611  
**2022 Work RVU:** 0.32  
**2022 NF PE RVU:** 0.60  
**2022 Fac PE RVU:** 0.07  
**Result:** Maintain  
**RUC Recommendation:** 0.32 (Interim)  
**Referral to CPT**  
**Referral to CPT Asst**  
**Published in CPT Asst:**
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<td>11721</td>
<td>Debridement of nail(s) by any method(s); 6 or more</td>
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<td>Debridement of Nail</td>
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**Most Recent RUC Meeting:** September 2011

**Specialty Developing Recommendation:** APMA

**First Identified:** October 2010

**2020 Medicare Utilization:** 5,311,737

**2022 Work RVU:** 0.54

**2022 NF PE RVU:** 0.72

**2022 Fac PE RVU:** 0.12

**Result:** Maintain

Referred to CPT

Referred to CPT Asst

Published in CPT Asst

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<td>11730</td>
<td>Avulsion of nail plate, partial or complete, simple; single</td>
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<td>Removal of Nail Plate</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** January 2016

**Specialty Developing Recommendation:** APMA

**First Identified:** July 2015

**2020 Medicare Utilization:** 325,804

**2022 Work RVU:** 1.05

**2022 NF PE RVU:** 2.29

**2022 Fac PE RVU:** 0.43

**Result:** Maintain

Referred to CPT

Referred to CPT Asst

Published in CPT Asst

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<tr>
<th>Code</th>
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<tr>
<td>11750</td>
<td>Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal</td>
<td>010</td>
<td>Excision of Nail Bed - HCPAC</td>
<td>010-Day Global Post-Operative Visits</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** September 2014

**Specialty Developing Recommendation:**

**First Identified:** January 2014

**2020 Medicare Utilization:** 168,490

**2022 Work RVU:** 1.58

**2022 NF PE RVU:** 3.06

**2022 Fac PE RVU:** 1.27

**Result:** Decrease

Referred to CPT

Referred to CPT Asst

Published in CPT Asst

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<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
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<td>11752</td>
<td>Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx</td>
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<td>Excision of Nail Bed - HCPAC</td>
<td>010-Day Global Post-Operative Visits</td>
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**Most Recent RUC Meeting:** January 2015

**Specialty Developing Recommendation:**

**First Identified:** January 2014

**2020 Medicare Utilization:**

**2022 Work RVU:**

**2022 NF PE RVU:**

**2022 Fac PE RVU:**

**Result:** Deleted from CPT

Referred to CPT

Referred to CPT Asst

Published in CPT Asst

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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>11755</th>
<th>Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)</th>
<th>Global: 000</th>
<th>Issue: Biopsy of Nail</th>
<th>Screen: CMS 000-Day Global Typically Reported with an E/M</th>
<th>Complete?</th>
<th>Yes</th>
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<td>Most Recent RUC Meeting: April 2017</td>
<td>First Identified: July 2016</td>
<td>2020 Medicare Utilization: 51,856</td>
<td>Referred to CPT Published in CPT Asst:</td>
<td>Complete?</td>
<td>Yes</td>
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<tr>
<td></td>
<td>RUC Recommendation: 1.25</td>
<td>2022 Work RVU: 1.25</td>
<td>2022 NF PE RVU: 2.32</td>
<td>2022 Fac PE RVU: 0.42</td>
<td>Result:</td>
<td>Decrease</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>11900</th>
<th>Injection, intralesional; up to and including 7 lesions</th>
<th>Global: 000</th>
<th>Issue: Skin Injection Services</th>
<th>Screen: Harvard Valued - Utilization over 100,000</th>
<th>Complete?</th>
<th>Yes</th>
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<td>Most Recent RUC Meeting: April 2010</td>
<td>First Identified: October 2009</td>
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<td>RUC Recommendation: 0.52</td>
<td>2022 Work RVU: 0.52</td>
<td>2022 NF PE RVU: 1.11</td>
<td>2022 Fac PE RVU: 0.29</td>
<td>Result:</td>
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<table>
<thead>
<tr>
<th>11901</th>
<th>Injection, intralesional; more than 7 lesions</th>
<th>Global: 000</th>
<th>Issue: Skin Injection Services</th>
<th>Screen: Harvard Valued - Utilization over 100,000</th>
<th>Complete?</th>
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<td>First Identified: February 2010</td>
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<td>RUC Recommendation: 0.80</td>
<td>2022 Work RVU: 0.80</td>
<td>2022 NF PE RVU: 1.20</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Screen</th>
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<tr>
<td>11980</td>
<td>Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)</td>
<td>000</td>
<td>Drug Delivery Implant Procedures</td>
<td>High Volume Growth2 / Different Performing Specialty from Survey</td>
<td>Yes</td>
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<td>2022 Work RVU: 1.10</td>
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<td>2022 NF PE RVU: 1.52</td>
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<td>2022 Fac PE RVU: 0.38</td>
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<td>2020 Medicare Utilization: 28,049</td>
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<td>Referred to CPT</td>
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<td>Result: Decrease</td>
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<tr>
<td>11981</td>
<td>Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)</td>
<td>000</td>
<td>Drug Delivery Implant Procedures</td>
<td>High Volume Growth1 / Different Performing Specialty from Survey</td>
<td>Yes</td>
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<td>2022 Work RVU: 1.14</td>
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<td>2022 NF PE RVU: 1.65</td>
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<td>2022 Fac PE RVU: 0.51</td>
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<tr>
<td>11982</td>
<td>Removal, non-biodegradable drug delivery implant</td>
<td>000</td>
<td>Drug Delivery Implant Procedures</td>
<td>High Volume Growth1 / Different Performing Specialty from Survey</td>
<td>Yes</td>
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<td>2022 Work RVU: 1.34</td>
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<td>2020 Medicare Utilization: 3,025</td>
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<td>Status Report: CMS Requests and Relativity Assessment Issues</td>
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<tr>
<td><strong>11983</strong> Removal with reinsertion, non-biodegradable drug delivery implant</td>
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<td><strong>Global:</strong> 000  <strong>Issue:</strong> Drug Delivery Implant Procedures</td>
<td><strong>Screen:</strong> High Volume Growth 1</td>
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<td><strong>Most Recent RUC Meeting:</strong> October 2018</td>
<td><strong>Tab:</strong> 05</td>
<td><strong>Specialty Developing Recommendation:</strong> AAOS, ACOG, AUA</td>
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<td><strong>First Identified:</strong> June 2008</td>
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<td><strong>RUC Recommendation:</strong> 2.10</td>
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<td><strong>2022 NF PE RVU:</strong> 1.99</td>
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<td><strong>2022 Fac PE RVU:</strong> 0.81</td>
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<td><strong>Result:</strong> Decrease</td>
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<table>
<thead>
<tr>
<th><strong>12001</strong> Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less</th>
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<tbody>
<tr>
<td><strong>Global:</strong> 000  <strong>Issue:</strong> Repair of Superficial Wounds</td>
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<tr>
<td><strong>Most Recent RUC Meeting:</strong> April 2010</td>
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<tr>
<td><strong>First Identified:</strong> October 2009</td>
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<td><strong>RUC Recommendation:</strong> 0.84</td>
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<table>
<thead>
<tr>
<th><strong>12002</strong> 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</th>
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<td><strong>Global:</strong> 000  <strong>Issue:</strong> Repair of Superficial Wounds</td>
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<td><strong>Most Recent RUC Meeting:</strong> April 2010</td>
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<tr>
<td><strong>First Identified:</strong> October 2009</td>
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<td><strong>RUC Recommendation:</strong> 1.14</td>
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<tr>
<th><strong>12004</strong> 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</th>
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<tbody>
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<td><strong>Global:</strong> 000  <strong>Issue:</strong> Repair of Superficial Wounds</td>
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<td><strong>RUC Recommendation:</strong> 1.44</td>
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<td>Repair of Superficial Wounds</td>
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### 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**
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 32
- **Specialty Developing Recommendation:** ACEP, AAFP
- **First Identified:** April 2010
- **2020 Medicare Utilization:** 5,583
- **RUC Recommendation:** 1.97
- **Result:** Decrease
- **Complete?** Yes
- **2022 Work RVU:** 1.97
- **2022 NF PE RVU:** 2.92
- **2022 Fac PE RVU:** 0.45
- **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**
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 32
- **Specialty Developing Recommendation:** ACEP, AAFP
- **First Identified:** April 2010
- **2020 Medicare Utilization:** 1,045
- **RUC Recommendation:** 2.39
- **Result:** Decrease
- **Complete?** Yes
- **2022 Work RVU:** 2.39
- **2022 NF PE RVU:** 3.31
- **2022 Fac PE RVU:** 0.59
- **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**
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 32
- **Specialty Developing Recommendation:** ACEP, AAFP
- **First Identified:** April 2010
- **2020 Medicare Utilization:** 365
- **RUC Recommendation:** 2.90
- **Result:** Decrease
- **Complete?** Yes
- **2022 Work RVU:** 2.90
- **2022 NF PE RVU:** 3.48
- **2022 Fac PE RVU:** 0.84
- **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**
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 32
- **Specialty Developing Recommendation:** ACEP, AAFP
- **First Identified:** April 2010
- **2020 Medicare Utilization:** 78,196
- **RUC Recommendation:** 1.07
- **Result:** Decrease
- **Complete?** Yes
- **2022 Work RVU:** 1.07
- **2022 NF PE RVU:** 2.07
- **2022 Fac PE RVU:** 0.35
- **Referred to CPT Asst Published in CPT Asst:**
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<td>12013</td>
<td>Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm</td>
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<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
<td>Decrease</td>
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<tr>
<td>12014</td>
<td>Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm</td>
<td>000</td>
<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
<td>Decrease</td>
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<tr>
<td>12015</td>
<td>Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm</td>
<td>000</td>
<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
<td>Decrease</td>
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<tr>
<td>12016</td>
<td>Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm</td>
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<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
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<td>Decrease</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>12017</td>
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<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
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<tr>
<td>12018</td>
<td>Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm</td>
<td>000</td>
<td>Repair of Superficial Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
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<td>12031</td>
<td>Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less</td>
<td>010</td>
<td>Repair of Intermediate Wounds</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 12032
** Issue: Repair of Intermediate Wounds**
** Global: 010 **
** 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
** Medicare Utilization: ** 281,588

- ** 2022 Work RVU: ** 2.52
- ** 2022 NF PE RVU: ** 6.24
- ** 2022 Fac PE RVU: ** 2.73

- ** Result: ** Keep

- ** Published in CPT Asst: **
- ** Referred to CPT Asst: ** Yes

### 12034
** Issue: Repair of Intermediate Wounds**
** Global: 010 **
** 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
** Medicare Utilization: ** 28,378

- ** 2022 Work RVU: ** 2.97
- ** 2022 NF PE RVU: ** 6.63
- ** 2022 Fac PE RVU: ** 2.63

- ** Result: ** Keep

- ** Published in CPT Asst: **
- ** Referred to CPT Asst: ** Yes

### 12035
** Issue: Repair of Intermediate Wounds**
** Global: 010 **
** 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
** Medicare Utilization: ** 5,035

- ** 2022 Work RVU: ** 3.50
- ** 2022 NF PE RVU: ** 7.51
- ** 2022 Fac PE RVU: ** 2.95

- ** Result: ** Increase

- ** Published in CPT Asst: **
- ** Referred to CPT Asst: ** Yes
### Status Report: CMS Requests and Relativity Assessment Issues

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Referred to CPT Asst | Published in CPT Asst: | Result: Increase

Referred to CPT Asst | Published in CPT Asst: | Result: Increase

Referred to CPT Asst | Published in CPT Asst: | Result: Decrease
## Status Report: CMS Requests and Relativity Assessment Issues

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## 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

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### 12053 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm

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### 12054 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

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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  | **2020 Medicare Utilization:** 175,826 |
| **RUC Recommendation:** 4.00  | **Referred to CPT:** September 2018  | **Referred to CPT Asst:** Published in CPT Asst:  | **Result:** Decrease  | **2022 Work RVU:** 4.00  |
|  |  |  |  | **2022 NF PE RVU:** 8.29  |
|  |  |  |  | **2022 Fac PE RVU:** 3.08  |
|  |  |  |  | **2020 Medicare Utilization:** 27,066  |
| **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  | **2020 Medicare Utilization:** 27,066 |
| **RUC Recommendation:** 1.44  | **Referred to CPT:** September 2018  | **Referred to CPT Asst:** Published in CPT Asst:  | **Result:** Maintain  | **2022 Work RVU:** 1.44  |
|  |  |  |  | **2022 NF PE RVU:** 2.14  |
|  |  |  |  | **2022 Fac PE RVU:** 0.77  |
| **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  | **2020 Medicare Utilization:** 31,462 |
| **RUC Recommendation:** 3.73  | **Referred to CPT**  | **Referred to CPT Asst:**  | **Result:** Decrease  | **2022 Work RVU:** 3.73  |
|  |  |  |  | **2022 NF PE RVU:** 7.44  |
|  |  |  |  | **2022 Fac PE RVU:** 2.91  |

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### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

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### Issue 15004
- **Description**: 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.
- **RUC Recommendation**: Maintain work RVU and adjust the times from pre-time package 4.
- **2020 Medicare Utilization**: 31,129
- **2022 Work RVU**: 4.58
- **2022 NF PE RVU**: 6.58
- **2022 Fac PE RVU**: 2.44

### Issue 15100
- **Description**: Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050).
- **RUC Recommendation**: Maintain work RVU and adjust the times from pre-time package 4.
- **2020 Medicare Utilization**: 12,169
- **2022 Work RVU**: 9.90
- **2022 NF PE RVU**: 14.08
- **2022 Fac PE RVU**: 9.32

### Issue 15120
- **Description**: 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).
- **RUC Recommendation**: Remove from screen
- **2020 Medicare Utilization**: 7,976
- **2022 Work RVU**: 10.15
- **2022 NF PE RVU**: 13.29
- **2022 Fac PE RVU**: 8.51

---

**Note:**
- **Tab:** 21
- **Specialty Developing Recommendation:** ASPS, APMA
- **First Identified:** January 2014
- **Pre-Time Analysis:**
  - 4.58
  - 6.58
  - 2.44
- **Referred to CPT:**
- **Referred to CPT Asst:**
- **Published in CPT Asst:**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less</td>
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<td>15240</td>
<td>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</td>
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<td>Pre-Time Analysis</td>
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<td>Chronic Wound Dermal Substitute</td>
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| 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) | ZZZ    | Chronic Wound Dermal Substitute | Different Performing Specialty from Survey | Yes       | 0.33     | 0.35      | 0.12       |
|            | **Most Recent RUC Meeting:** April 2011 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 | 2020   | Medicare Utilization: 16,178   | February 2011 | Referred to CPT | Result: Decrease |
|            | **RUC Recommendation:** 0.59                                                      |        |        |        |           |          |            |            |
|            | **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 | 0.00   | Chronic Wound Dermal Substitute | Different Performing Specialty from Survey | Yes       | 3.50     | 5.32      | 1.67       |
|            | **Most Recent RUC Meeting:** April 2011 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 | 2020   | Medicare Utilization: 6,606    | February 2011 | Referred to CPT | Result: Decrease |
|            | **RUC Recommendation:** 3.50                                                      |        |        |        |           |          |            |            |
|            | **Published in CPT Asst:**                                                        |        |        |        |           |          |            |            |
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>15276</td>
<td>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)</td>
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### 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.**

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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).**

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| **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                          |
| **2020 Medicare Utilization:**                               |
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| **Referred to CPT Asst Published in CPT Asst:**               |
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| <strong>Referred to CPT Asst Published in CPT Asst:</strong>               |
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**Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

**Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)**

**Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**
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<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<tr>
<td><strong>15732</strong> Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)</td>
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| **15733** Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae) |
| Global: | Issue: Muscle Flaps |
| Screen: | Complete? Yes |
| Most Recent RUC Meeting: January 2017 |
| Tab: 05 | Specialty Developing Recommendation: ASPS |
| First Identified: | January 2017 |
| 2020 Medicare Utilization: | 4,903 |
| 2022 Work RVU: | 15.68 |
| 2022 NF PE RVU: | NA |
| 2022 Fac PE RVU: | 12.24 |
| RUC Recommendation: | 15.68 |
| Referred to CPT |
| Referred to CPT Asst | Published in CPT Asst: |
| Result: Decrease |

| **15734** Muscle, myocutaneous, or fasciocutaneous flap; trunk |
| Global: | Issue: Muscle Flaps |
| Screen: | Complete? Yes |
| Most Recent RUC Meeting: April 2016 |
| Tab: 14 | Specialty Developing Recommendation: |
| First Identified: | October 2015 |
| 2020 Medicare Utilization: | 21,710 |
| 2022 Work RVU: | 23.00 |
| 2022 NF PE RVU: | NA |
| 2022 Fac PE RVU: | 16.61 |
| RUC Recommendation: | 23.00 |
| Referred to CPT |
| Referred to CPT Asst | Published in CPT Asst: |
| Result: Increase |
## Status Report: CMS Requests and Relativity Assessment Issues

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| 15738| Muscle, myocutaneous, or fasciocutaneous flap; lower extremity               | 090    | Muscle Flaps            | High Level E/M in Global Period             | Yes      | 19.04 |
|      | **Most Recent RUC Meeting:** April 2016                                      |        | **Specialty Developing** | ASPS                                        |          | 14   |
|      | **Tab:** 14                                                                  |        | **First Identified:**   | January 2016                                |          |      |
|      | **Issue:** Specialty Developing                                               |        | **2020 Medicare Utilization:** | 5,804                                      |          |      |
|      | **Screen:** RUC Recommendation:                                              |        | **Result:** Maintain    |                                             |          |      |
|      | **2022 Work RVU:** 19.04                                                      |        | **Complete?** Yes       |                                             |          |      |
|      | **2022 NF PE RVU:** NA                                                        |        | **Complete?** Yes       |                                             |          |      |
|      | **2022 Fac PE RVU:** 15.04                                                    |        | **Complete?** Yes       |                                             |          |      |
|      | **RUC Recommendation:** 19.04                                                 |        | **Published in CPT Asst:** |                                          |          |      |
|      | **Referred to CPT Asst:** October 2016                                       |        | **2022 Fac PE RVU:** 15.04 |                                             |          |      |

| 15740| Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel | 090    | Dermatology and Plastic Surgery Procedures | Site of Service Anomaly / CMS Fastest Growing | Yes      | 11.57 |
|      | **Most Recent RUC Meeting:** April 2008                                       |        | **Specialty Developing** | AAD, ASPS                                   |          | 28   |
|      | **Tab:** 28                                                                  |        | **First Identified:**   | September 2007                              |          |      |
|      | **Issue:** Specialty Developing                                               |        | **2020 Medicare Utilization:** | 1,896                                       |          |      |
|      | **Screen:** RUC Recommendation:                                              |        | **Result:** Maintain    |                                             |          |      |
|      | **2022 Work RVU:** 11.80                                                      |        | **Complete?** Yes       |                                             |          |      |
|      | **2022 NF PE RVU:** 16.23                                                      |        | **Complete?** Yes       |                                             |          |      |
|      | **2022 Fac PE RVU:** 11.09                                                    |        | **Complete?** Yes       |                                             |          |      |
|      | **RUC Recommendation:** 11.57                                                 |        | **Published in CPT Asst:** |                                          |          |      |
|      | **Referred to CPT Asst:** October 2009 & February 2012                       |        | **2022 Fac PE RVU:** 11.09 |                                             |          |      |

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*Tuesday, February 1, 2022*
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| 15771 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate | 090    | Tissue Grafting Procedures | Site of Service Anomaly - 2017 | Yes       | October 2018            | 04  | ASPS                     | May 2018         | 2,564       | 9.56      | 6.68       | Increase |
|       |                                                                               |        |                        |                                     |           |                         |     |                         | Referred to CPT |             |           |            |        |
|       |                                                                               |        |                        |                                     |           |                         |     |                         | Published in CPT Asst |             |           |            |        |

<p>| 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) | ZZZ    | Tissue Grafting Procedures | Site of Service Anomaly - 2017 | Yes       | October 2018            | 04  | ASPS                     | May 2018         | 5,007       | 2.66      | 1.40       | Increase |
|       |                                                                               |        |                        |                                     |           |                         |     |                         | Referred to CPT |             |           |            |        |
|       |                                                                               |        |                        |                                     |           |                         |     |                         | Published in CPT Asst |             |           |            |        |</p>
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<td><strong>15773</strong> 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</td>
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**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 | **2020 Medicare Utilization**: 87 |  |
| Referred to CPT | **2022 Work RVU**: 2.41 | **2022 NF PE RVU**: 2.66 |
| Referred to CPT Asst | **2022 Fac PE RVU**: 1.39 |  |
| Complete? | 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 | **2020 Medicare Utilization**: 7,449 |  |
| Referred to CPT | **2022 Work RVU**: 3.65 | **2022 NF PE RVU**: 1.97 |
| Referred to CPT Asst | **2022 Fac PE RVU**: 1.97 |  |
| Complete? | Published in CPT Asst: |  |
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Screen: Different Performing Specialty from Survey</th>
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<td>RUC Recommendation: 0.80</td>
<td>Most Recent RUC Meeting: October 2009</td>
<td>Specialty Developing Recommendation: ASPS, AAFP, AAPMR, ACS, AAP</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>16025</th>
<th>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)</th>
<th>Global: 000</th>
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<th>Screen: Different Performing Specialty from Survey</th>
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<th>16030</th>
<th>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)</th>
<th>Global: 000</th>
<th>Issue: Dressings/ Debridement of Partial-Thickness Burns</th>
<th>Screen: Different Performing Specialty from Survey</th>
<th>Complete?</th>
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<th>17000</th>
<th>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); first lesion</th>
<th>Global: 010</th>
<th>Issue: Destruction of Premalignant Lesions</th>
<th>Screen: MPC List</th>
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<td>Tab: 17 Specialty Developing Recommendation: AAD</td>
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<td>2022 Work RVU: 0.61</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 17003

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

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<tr>
<th>Global: ZZZ</th>
<th>Issue: Destruction of Premalignant Lesions</th>
<th>Screen: Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1</th>
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<td>2022 NF PE RVU: 0.16</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>7.49</td>
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<td>High Volume Growth</td>
<td>Yes</td>
<td>0.70</td>
<td>2.59</td>
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<td>010</td>
<td>RAW</td>
<td>High Volume Growth2</td>
<td>Yes</td>
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**RUC Meeting:** October 2013  
**Tab:** 18  
**Specialty Developing Recommendation:** Remove from screen  
**First Identified:** April 2013  
**2020 Medicare Utilization:** 104,490  
**2022 Work RVU:** 0.97  
**2022 NF PE RVU:** 2.87  
**2022 Fac PE RVU:** 1.31  
**Referred to CPT:** [ ]  
**Published in CPT Asst:** [ ]  
**Result:** Remove from screen

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<td>17250</td>
<td>Chemical cauterization of granulation tissue (ie, proud flesh)</td>
<td>000</td>
<td>Chemical Cauterization of Granulation Tissue</td>
<td>High Volume Growth3</td>
<td>No</td>
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**RUC Meeting:** January 2022  
**Tab:** 20  
**Specialty Developing Recommendation:** AAFP, ACS, APMA  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 242,534  
**2022 Work RVU:** 0.50  
**2022 NF PE RVU:** 2.09  
**2022 Fac PE RVU:** 0.51  
**Referred to CPT:** September 2016  
**Published in CPT Asst:** Sep 2016  
**Result:** Review in 3 years (Jan 2025)

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<td>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm</td>
<td>010</td>
<td>Destruction of Malignant Lesion</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
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**RUC Meeting:** October 2010  
**Tab:** 26  
**Specialty Developing Recommendation:** AAD, AAFP  
**First Identified:** October 2009  
**2020 Medicare Utilization:** 122,481  
**2022 Work RVU:** 1.22  
**2022 NF PE RVU:** 3.05  
**2022 Fac PE RVU:** 1.18  
**Referred to CPT:** [ ]  
**Published in CPT Asst:** [ ]  
**Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>1.63</td>
<td>3.50</td>
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<td>17271</td>
<td>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemo surgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm</td>
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<td>17272</td>
<td>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemo surgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm</td>
<td>010</td>
<td>Destruction of Malignant Lesion</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
<td>1.82</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Issue</th>
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<th>NF PE RVU</th>
<th>Fac PE RVU</th>
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<td>17281</td>
<td>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curetttement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm</td>
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<td>Harvard Valued - Utilization over 100,000</td>
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<td>Destruction of Malignant Lesion</td>
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<td>17311</td>
<td>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</td>
<td>CMS High Expenditure Procedural Codes1</td>
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<td>Mohs Surgery</td>
<td>18</td>
<td>AAD</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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)</td>
<td>2022 Work RVU: 3.30</td>
<td>Mohs Surgery</td>
<td>CMS High Expenditure Procedural Codes</td>
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<td>17313</td>
<td>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</td>
<td>2022 Work RVU: 5.56</td>
<td>Mohs Surgery</td>
<td>CMS High Expenditure Procedural Codes</td>
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<td>17314</td>
<td>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)</td>
<td>2022 Work RVU: 3.06</td>
<td>Mohs Surgery</td>
<td>CMS High Expenditure Procedural Codes</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>Mohs Surgery</td>
<td>ZZZ</td>
<td>CMS High Expenditure Procedural Codes</td>
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**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)

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<th>April 2013</th>
<th>Tab: 18</th>
<th>Specialty Developing Recommendation: AAD</th>
<th>First Identified: January 2012</th>
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<td>Result:</td>
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**19020** Mastotomy with exploration or drainage of abscess, deep

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<td>RUC Recommendation:</td>
<td>Reduce 99238 to 0.5, remove hospital visits</td>
<td>Referred to CPT</td>
<td>Refer to CPT Asst</td>
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**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

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<td>19082</td>
<td>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)</td>
<td>ZZZ</td>
<td>Breast Biopsy</td>
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<td>2022 Fac PE RVU: 1.12</td>
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<td>19083</td>
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<td>Breast Biopsy</td>
<td>Referred to CPT</td>
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<td>2020 Work RVU: 1.55</td>
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### 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**

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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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- **Tab: 04** Specialty Developing recommendation: ACR, ACS, ASBS
- **First Identified:** January 2012
- **2020 Medicare Utilization:** 5,690
- **RUC Recommendation:** 3.64
- **Result:** Decrease

**Referred to CPT:** October 2012
**Referred to 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)**

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- **Tab: 04** Specialty Developing recommendation: ACR, ACS, ASBS
- **First Identified:** January 2012
- **2020 Medicare Utilization:** 1,151
- **RUC Recommendation:** 1.82
- **Result:** Decrease

**Referred to CPT:** October 2012
**Referred to CPT Asst:**

#### 19102

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

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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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- **Tab: 04** Specialty Developing recommendation: ACR, ACS, ASBS
- **First Identified:** January 2012
- **2020 Medicare Utilization:**
- **RUC Recommendation:** Deleted from CPT
- **Result:** Deleted from CPT

**Referred to CPT:** October 2012
**Referred to CPT Asst:**

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance</td>
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<td>Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
**Tab:** 04  
**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** January 2012  
**2020 Medicare Utilization:**  
**Result:** Deleted from CPT  
**Refer to CPT:** October 2012  
**Refer to CPT Asst:**  

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<td>19281</td>
<td>Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance</td>
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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
**Tab:** 04  
**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** January 2012  
**2020 Medicare Utilization:**  
**Result:** Decrease  
**Refer to CPT:** October 2012  
**Refer to CPT Asst:**  

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<td>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)</td>
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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
**Tab:** 04  
**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** January 2012  
**2020 Medicare Utilization:**  
**Result:** Decrease  
**Refer to CPT:** October 2012  
**Refer to CPT Asst:**  

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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<td>19285</td>
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<td>000</td>
<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<tr>
<th>19286</th>
<th>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)</th>
<th>Global: ZZZ</th>
<th>Issue: Breast Biopsy</th>
<th>Screen: Codes Reported Together 75% or More-Part2</th>
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<td>Medicare Utilization: 1,932</td>
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<tr>
<th>19287</th>
<th>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance</th>
<th>Global: 000</th>
<th>Issue: Breast Biopsy</th>
<th>Screen: Codes Reported Together 75% or More-Part2</th>
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<tr>
<th>19288</th>
<th>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)</th>
<th>Global: ZZZ</th>
<th>Issue: Breast Biopsy</th>
<th>Screen: Codes Reported Together 75% or More-Part2</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 19290 Preoperative placement of needle localization wire, breast;

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<th>Issue</th>
<th>Screen</th>
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<tbody>
<tr>
<td></td>
<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
**Tab:** 04  
**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** January 2012  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  

**Result:** Deleted from CPT

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

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<th>Global</th>
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<th>Screen</th>
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<tbody>
<tr>
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<td>Breast Biopsy</td>
<td>Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
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**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** January 2012  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  

**Result:** Deleted from CPT

### 19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)

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<th>Global</th>
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<th>Screen</th>
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<tbody>
<tr>
<td></td>
<td>Breast Biopsy</td>
<td>CMS Fastest Growing / Codes Reported Together 75% or More-Part2</td>
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**Most Recent RUC Meeting:** April 2013  
**Tab:** 04  
**Specialty Developing Recommendation:** ACR, ACS, ASBS  
**First Identified:** October 2008  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  

**Result:** Deleted from CPT
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Issue</th>
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<th>Work RVU</th>
<th>NF PE RVU</th>
<th>Fac PE RVU</th>
<th>Medicare Utilization</th>
<th>Result</th>
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<tbody>
<tr>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
<td>090</td>
<td>Mastectomy</td>
<td>Site of Service Anomaly - 2015 / High Level E/M in Global Period</td>
<td>Yes</td>
<td>15.00</td>
<td>NA</td>
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<tr>
<td>19307</td>
<td>Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle</td>
<td>090</td>
<td>Modified Radical Mastectomy</td>
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<tr>
<td>19318</td>
<td>Breast reduction</td>
<td>090</td>
<td>Mammaplasty</td>
<td>Site of Service Anomaly (99238-Only)</td>
<td>Yes</td>
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<td>19340</td>
<td>Insertion of breast implant on same day of mastectomy (ie, immediate)</td>
<td>090</td>
<td>Breast Implant/Expander Placement</td>
<td>CMS Request / Site of Service Anomaly - 2019</td>
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<td>Most Recent RUC Meeting: January 2020</td>
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<td>2020 Medicare Utilization: 6,133</td>
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</table>

| 19357          | Tissue expander placement in breast reconstruction, including subsequent expansion(s) | 090    | Breast Implant/Expander Placement                                                  | CMS Request / Site of Service Anomaly - 2019 | Yes      |
|                | Most Recent RUC Meeting: January 2020                                            |        |       | 2020 Medicare Utilization: 5,820                                                   |          |
|                | Specialty Developing Recommendation: ASPS                                         |        |       | 2022 Work RVU: 14.84                                                               |          |
|                | First Identified: September 2007                                                  |        |       | 2022 NF PE RVU: NA                                                                 |          |
|                | RUC Recommendation: 15.36                                                         |        |       | 2022 Fac PE RVU: 16.66                                                            |          |
|                | Referred to CPT                                                                   |        |       | Result: Decrease                                                                  |          |
|                | Published in CPT Asst                                                             |        |       |                                      |          |

<p>| 20000          | Deleted from CPT                                                                  |        | Incision of Abscess                                                              | Site of Service Anomaly (99238-Only) | Yes      |
|                | Most Recent RUC Meeting: September 2007                                           |        |       | 2020 Medicare Utilization:                                                        |          |
|                | Specialty Developing Recommendation: APMA, AAOS                                    |        |       | 2022 Work RVU:                                                                    |          |
|                | First Identified: September 2007                                                  |        |       | 2022 NF PE RVU:                                                                   |          |
|                | RUC Recommendation: Deleted from CPT                                               |        |       | 2022 Fac PE RVU:                                                                  |          |
|                | Referred to CPT                                                                   |        |       | Result: Deleted from CPT                                                           |          |
|                | Published in CPT Asst                                                             |        |       |                                      |          |</p>
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<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<tbody>
<tr>
<td><strong>20005</strong> Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)</td>
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<td><strong>Most Recent RUC Meeting:</strong> October 2017</td>
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<td><strong>RUC Recommendation:</strong> Deleted from CPT</td>
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<tr>
<td><strong>20220</strong> Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)</td>
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<td><strong>Most Recent RUC Meeting:</strong> January 2019</td>
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<tr>
<td><strong>RUC Recommendation:</strong> 1.93</td>
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<td><strong>20225</strong> Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)</td>
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<td><strong>Most Recent RUC Meeting:</strong> January 2019</td>
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<td><strong>RUC Recommendation:</strong> 3.00</td>
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<tr>
<td><strong>20240</strong> Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)</td>
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<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2016</td>
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<td>Status Report: CMS Requests and Relativity Assessment Issues</td>
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<tr>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>20245</strong> Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)</td>
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<td><strong>Most Recent RUC Meeting:</strong> January 2016</td>
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<tr>
<td><strong>RUC Recommendation:</strong> 6.50</td>
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<tr>
<th>20525 Removal of foreign body in muscle or tendon sheath; deep or complicated</th>
<th><strong>Global:</strong> 010</th>
<th><strong>Issue:</strong> Removal of Foreign Body</th>
<th><strong>Screen:</strong> Site of Service Anomaly (99238-Only)</th>
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<tr>
<td><strong>Most Recent RUC Meeting:</strong> September 2007</td>
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<td><strong>Specialty Developing Recommendation:</strong> ACS, AAOS</td>
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<td><strong>2022 Fac PE RVU:</strong> 3.12</td>
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<td><strong>Published in CPT Asst:</strong></td>
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<th>20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel</th>
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<th><strong>Issue:</strong> RAW</th>
<th><strong>Screen:</strong> CMS 000-Day Global Typically Reported with an E/M</th>
<th><strong>Complete?</strong> Yes</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
</tr>
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<tbody>
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<td>20550</td>
<td>Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar &quot;fascia&quot;)</td>
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<td>Injection of Tendon</td>
<td>CMS Fastest Growing / CMS High Expenditure Procedural Codes2</td>
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<td>20551</td>
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**Notes:**
- **Most Recent RUC Meeting:** January 2016
- **Specialty Developing Recommendation:** AAOS, AAPM&R, ACRh, APMA, ASSH
- **First Identified:** October 2008
- **Medicare Utilization:**
  - 2020: 754,987
- **Result:** Maintain
- **Screened:**
  - CMS Fastest Growing / CMS High Expenditure Procedural Codes2
  - CMS 000-Day Global Typically Reported with an E/M
- **Published in CPT Asst:**

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**Tuesday, February 1, 2022**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>0.68 and new PE inputs</td>
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| 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 | 000    | Arthrocentesis | CMS Request - Final Rule for 2014 | Yes | 1.00 |
|       | **Most Recent RUC Meeting:** January 2014                                   |        |       |        |           |       |
|       | **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH  |        |       |        |           |       |
|       | **First Identified:** July 2013                                            |        |       |        |           |       |
|       | **2020 Medicare Utilization:** 52,205                                       |        |       |        |           |       |
|       | **2022 Work RVU:** 1.00                                                     |        |       |        |           |       |
|       | **2022 NF PE RVU:** 1.53                                                    |        |       |        |           |       |
|       | **2022 Fac PE RVU:** 0.41                                                   |        |       |        |           |       |
|       | **RUC Recommendation:** 1.00                                                 |        |       |        |           |       |
|       | **Referred to CPT** October 2013                                            |        |       |        |           |       |
|       | **Published in CPT Asst:**                                                  |        |       |        |           |       |
|       | **Result:** Decrease                                                         |        |       |        |           |       |

| 20610 | Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance | 000    | Arthrocentesis | Harvard Valued - Utilization over 100,000 | Yes | 0.79 and new PE inputs |
|       | **Most Recent RUC Meeting:** January 2014                                   |        |       |        |           |       |
|       | **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH  |        |       |        |           |       |
|       | **First Identified:** February 2010                                         |        |       |        |           |       |
|       | **2020 Medicare Utilization:** 5,497,402                                    |        |       |        |           |       |
|       | **2022 Work RVU:** 0.79                                                     |        |       |        |           |       |
|       | **2022 NF PE RVU:** 1.01                                                    |        |       |        |           |       |
|       | **2022 Fac PE RVU:** 0.42                                                   |        |       |        |           |       |
|       | **RUC Recommendation:** 0.79 and new PE inputs                              |        |       |        |           |       |
|       | **Referred to CPT** October 2013                                            |        |       |        |           |       |
|       | **Published in CPT Asst:**                                                  |        |       |        |           |       |
|       | **Result:** Maintain                                                         |        |       |        |           |       |
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, ilizarov, monticelli type)</td>
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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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

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<th>Tab</th>
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### 20902  Bone graft, any donor area; major or large

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

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### 21015  Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>21557</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm</td>
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<td>Radical Resection of Soft Tissue Tumor</td>
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<td>21800</td>
<td>Closed treatment of rib fracture, uncomplicated, each</td>
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Tuesday, February 1, 2022
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<td>21805 Open treatment of rib fracture without fixation, each</td>
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<td>21810 Treatment of rib fracture requiring external fixation (flail chest)</td>
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<td>21811 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs</td>
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<td>CMS Request - Final Rule for 2014</td>
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<td><strong>21813</strong> Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs</td>
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**Tab:** 05  
**Specialty Developing Recommendation:** STS, ACS  
**First Identified:** January 2014  
**RUC Recommendation:** 35.00 |
| **Issue:** Internal Fixation of Rib Fracture  
**Screen:** CMS Request - Final Rule for 2014  
**Complete?** Yes  
**2022 Work RVU:** 17.61  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 7.12 |
| **Global:** 000  
**Medicare Utilization:** 67 |
| **Result:** Decrease  
**Referred to CPT Asst:** Published in CPT Asst: |
| **2020 Medicare Utilization:** 67 |
| **21820** Closed treatment of sternum fracture |
| **Most Recent RUC Meeting:** April 2016  
**Tab:** 46  
**Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties  
**First Identified:** January 2014  
**RUC Recommendation:** PE Clinical staff pre-time revised |
| **Issue:** Internal Fixation of Rib Fracture  
**Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures  
**Complete?** Yes  
**2022 Work RVU:** 1.36  
**2022 NF PE RVU:** 2.82  
**2022 Fac PE RVU:** 2.73 |
| **Global:** 090  
**Medicare Utilization:** 135 |
| **Result:** PE Only  
**Referred to CPT:** October 2013  
**Referred to CPT Asst:** Published in CPT Asst: Jan 2018 |
| **21825** Open treatment of sternum fracture with or without skeletal fixation |
| **Most Recent RUC Meeting:** April 2014  
**Tab:** 05  
**Specialty Developing Recommendation:** STS, ACS  
**First Identified:** January 2014  
**RUC Recommendation:** Unrelated to the family |
| **Issue:** Internal Fixation of Rib Fracture  
**Screen:** CMS Request - Final Rule for 2014  
**Complete?** Yes  
**2022 Work RVU:** 7.76  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.79 |
| **Global:** 090  
**Medicare Utilization:** 549 |
| **Result:** Remove from screen  
**Referred to CPT:** October 2013  
**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

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<td>Radical Resection of Soft Tissue Tumor</td>
<td>Site of Service Anomaly</td>
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- **Most Recent RUC Meeting:** February 2009
- **Specialty Developing Recommendation:** ACS, AAOS
- **First Identified:** September 2007
- **2020 Medicare Utilization:** 213
- **2022 Work RVU:** 15.72
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 11.21
- **RUC Recommendation:** 15.54
- **Referred to CPT:** June 2008
- **Result:** Decrease

#### 22214  Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar

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- **Most Recent RUC Meeting:** September 2014
- **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS
- **First Identified:** October 2008
- **2020 Medicare Utilization:** 6,664
- **2022 Work RVU:** 21.02
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 17.88
- **RUC Recommendation:** Maintain
- **Referred to CPT**
- **Result:** Maintain

#### 22305  Closed treatment of vertebral process fracture(s)

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- **Most Recent RUC Meeting:** April 2015
- **Specialty Developing Recommendation:** AANS/CNS, NASS
- **First Identified:** July 2013
- **2020 Medicare Utilization:**
- **2022 Work RVU:**
- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**
- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT**
- **Result:** Deleted from CPT

#### 22310  Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing

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- **Most Recent RUC Meeting:** January 2020
- **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS
- **First Identified:** April 2017
- **2020 Medicare Utilization:** 5,711
- **2022 Work RVU:** 3.45
- **2022 NF PE RVU:** 5.06
- **2022 Fac PE RVU:** 4.64
- **RUC Recommendation:** 3.45. Flag for Rereview
- **Referred to CPT**
- **Result:** Decrease

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Tuesday, February 1, 2022
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# Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
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| **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 Augmentation |
| 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 |
| Referral to CPT February 2014 |
| Referral to CPT Asst Published in CPT Asst: |
| Result: Deleted from CPT |
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| 2022 NF PE RVU: |
| 2022 Fac PE RVU: |
| Global: First Identified: September 2011 Medicare Utilization: 2020 |
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| RUC Recommendation: Deleted from CPT |

| **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 Augmentation |
| 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 |
| Referral to CPT February 2014 |
| Referral to CPT Asst Published in CPT Asst: |
| Result: Deleted from CPT |
| 2022 Work RVU: |
| 2022 NF PE RVU: |
| 2022 Fac PE RVU: |
| Global: First Identified: September 2011 Medicare Utilization: 2020 |
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| RUC Recommendation: Deleted from CPT |
**Status Report: CMS Requests and Relativity Assessment Issues**

### 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  
**2020 Medicare Utilization:** 582  
**2022 Work RVU:** 24.79  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 18.16

**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  
**2020 Medicare Utilization:** 33,372  
**2022 Work RVU:** 25.00  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 17.63

**RUC Recommendation:** 24.50  
**Referred to CPT** October 2009  
**Result:** Decrease  
**Referred to CPT Asst Published in CPT Asst:**

### 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  
**2020 Medicare Utilization:** 29,861  
**2022 Work RVU:** 6.50  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 3.18

**RUC Recommendation:** 6.50  
**Referred to CPT** October 2009  
**Result:** Maintain  
**Referred to CPT Asst Published in CPT Asst:**

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<td>22585</td>
<td>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)</td>
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**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
- **2020 Medicare Utilization:** 4,006
- **2022 Work RVU:** 17.69
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 14.26
- **Referral to CPT:** October 2009
- **Published in CPT Asst?** Yes

**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
- **2020 Medicare Utilization:** 18,435
- **2022 Work RVU:** 23.53
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 15.57
- **Referral to CPT:** September 2016
- **Published in CPT Asst?** No

**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
- **2020 Medicare Utilization:** 15,353
- **2022 Work RVU:** 5.52
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.54
- **Referral to CPT:** October 2009
- **Published in CPT Asst?** Yes

**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
- **2020 Medicare Utilization:** 4,006
- **2022 Work RVU:** 17.69
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 14.26
- **Referral to CPT:** October 2009
- **Published in CPT Asst?** Yes

**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
- **2020 Medicare Utilization:** 18,435
- **2022 Work RVU:** 23.53
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 15.57
- **Referral to CPT:** September 2016
- **Published in CPT Asst?** No

**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
- **2020 Medicare Utilization:** 15,353
- **2022 Work RVU:** 5.52
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.54
- **Referral to CPT:** October 2009
- **Published in CPT Asst?** Yes
### Status Report: CMS Requests and Relativity Assessment Issues

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<th><strong>Issue:</strong> Lumbar Arthrodesis</th>
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- **RUC Recommendation:** Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4.
- **Referral:** Referred to CPT October 2010
- **Result:** Maintain

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<td><strong>2020 Medicare Utilization:</strong> 134,805</td>
<td><strong>2022 Work RVU:</strong> 6.43</td>
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- **RUC Recommendation:** 6.43
- **Referral:** Referred to CPT
- **Result:** Decrease

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- **RUC Recommendation:** 22.09
- **Referral:** Referred to CPT October 2010
- **Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>22633</td>
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<td>22634</td>
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<td>Lumbar Arthrodesis</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 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)

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#### 22849  Reinsertion of spinal fixation device

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#### 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)

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## Status Report: CMS Requests and Relativity Assessment Issues

### 22859
Insertion of intervertebral biomechanical device(s) (e.g., 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)

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2020 Medicare Utilization: 1,628

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### 22867
Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

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2020 Medicare Utilization: 1,608

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### 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)

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2020 Medicare Utilization: 331

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Tuesday, February 1, 2022

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<th>Code</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 23350 Injection procedure for shoulder arthrography or enhanced ct/mri shoulder arthrography

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### 23405 Tenotomy, shoulder area; single tendon

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### 23410 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute

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### 23412 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic

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**Tuesday, February 1, 2022**

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### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** October 2015  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** October 2008  
**2020 Medicare Utilization:** 57,646  
**2022 Work RVU:** 22.13  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 16.31  
**Result:** Remove from Screen

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

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**Most Recent RUC Meeting:** April 2016  
**Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 283  
**2022 Work RVU:** 2.36  
**2022 NF PE RVU:** 4.36  
**2022 Fac PE RVU:** 4.25  
**Result:** PE Only

**RUC Recommendation:** PE Clinical staff pre-time revised  
**Referred to CPT**  
**Published in CPT Asst:** Jan 2018

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**Specialty Developing Recommendation:** AAOS  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 28,950  
**2022 Work RVU:** 3.00  
**2022 NF PE RVU:** 6.44  
**2022 Fac PE RVU:** 5.91  
**Result:** Decrease

**RUC Recommendation:** 3.00  
**Referred to CPT**  
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**Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 162  
**2022 Work RVU:** 4.10  
**2022 NF PE RVU:** 6.63  
**2022 Fac PE RVU:** 5.65  
**Result:** PE Only

**RUC Recommendation:** PE Clinical staff pre-time revised  
**Referred to CPT**  
**Published in CPT Asst:** Jan 2018
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 24600 Treatment of closed elbow dislocation; without anesthesia

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**RUC Recommendation:** PE Clinical staff pre-time revised

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**Referral to CPT Asst:** Published in CPT Asst: Jan 2018

**Result:** PE Only

### 24605 Treatment of closed elbow dislocation; requiring anesthesia

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**RUC Recommendation:** PE Clinical staff pre-time revised

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**Referral to CPT Asst:** Published in CPT Asst: Jan 2018

**Result:** PE Only

### 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

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**RUC Recommendation:** 7.56

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**Referral to CPT Asst:** |

**Result:** Maintain

### 25210 Carpectomy; 1 bone

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**RUC Recommendation:** Reduce 99238 to 0.5

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**Referral to CPT Asst:** |

**Result:** PE Only
### Status Report: CMS Requests and Relativity Assessment Issues

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| 25280 | Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, | 090    | Tendon Repair | Site of Service Anomaly (99238-Only) | Yes       |
|       | single, each tendon                                                         |        |           |                                   |           |
|       | **Most Recent RUC Meeting:** September 2007                                 |        |           |                                   |           |
|       | **Tab:** 16                                                                 |        |           |                                   |           |
|       | **Specialty Developing Recommendation:** AAOS                              |        |           |                                   |           |
|       | **First Identified:** September 2007                                        |        |           |                                   |           |
|       | **Medicare Utilization:** 1,248                                              |        |           |                                   |           |
|       | **RUC Recommendation:** Reduce 99238 to 0.5                                 |        |           |                                   |           |
|       | **Referred to CPT**                                                         |        |           |                                   |           |
|       | **Result:** PE Only                                                         |        |           |                                   |           |
|       | **Published in CPT Asst:**                                                  |        |           |                                   |           |
|       | **2022 Work RVU:** 7.39                                                     |        |           |                                   |           |
|       | **2022 NF PE RVU:** NA                                                      |        |           |                                   |           |
|       | **2022 Fac PE RVU:** 8.12                                                   |        |           |                                   |           |

| 25310 | Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, | 090    | Forearm Repair | Site of Service Anomaly (99238-Only) | Yes       |
|       | single; each tendon                                                         |        |           |                                   |           |
|       | **Most Recent RUC Meeting:** February 2008                                  |        |           |                                   |           |
|       | **Tab:** 15                                                                 |        |           |                                   |           |
|       | **Specialty Developing Recommendation:** ASSH, AAOS                         |        |           |                                   |           |
|       | **First Identified:** September 2007                                        |        |           |                                   |           |
|       | **Medicare Utilization:** 6,280                                              |        |           |                                   |           |
|       | **RUC Recommendation:** 7.94                                                 |        |           |                                   |           |
|       | **Referred to CPT**                                                         |        |           |                                   |           |
|       | **Result:** Decrease                                                        |        |           |                                   |           |
|       | **Published in CPT Asst:**                                                  |        |           |                                   |           |
|       | **2022 Work RVU:** 8.08                                                     |        |           |                                   |           |
|       | **2022 NF PE RVU:** NA                                                      |        |           |                                   |           |
|       | **2022 Fac PE RVU:** 8.91                                                   |        |           |                                   |           |

| 25565 | Closed treatment of radial and ulnar shaft fractures; with manipulation       | 090    | PE Subcommittee | Emergent Procedures               | Yes       |
|       |                                                                                 |        |           |                                   |           |
|       | **Most Recent RUC Meeting:** April 2016                                       |        |           |                                   |           |
|       | **Tab:** 46                                                                   |        |           |                                   |           |
|       | **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties |        |           |                                   |           |
|       | **First Identified:** October 2015                                            |        |           |                                   |           |
|       | **Medicare Utilization:** 532                                                 |        |           |                                   |           |
|       | **RUC Recommendation:** PE Clinical staff pre-time revised                   |        |           |                                   |           |
|       | **Referred to CPT**                                                         |        |           |                                   |           |
|       | **Result:** PE Only                                                         |        |           |                                   |           |
|       | **Published in CPT Asst:**                                                  |        |           |                                   |           |
|       | **2022 Work RVU:** 5.85                                                     |        |           |                                   |           |
|       | **2022 NF PE RVU:** 8.57                                                     |        |           |                                   |           |
|       | **2022 Fac PE RVU:** 6.94                                                   |        |           |                                   |           |
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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</table>
## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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</thead>
<tbody>
<tr>
<td>25608</td>
<td>Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments</td>
<td>090</td>
<td>RAW</td>
<td>Pre-Time Analysis</td>
<td>Yes</td>
<td>11.07</td>
<td>NA</td>
<td>11.36</td>
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<tr>
<td></td>
<td>Maintain work RVU and adjust the times from pre-time package 3.</td>
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<tr>
<td>25609</td>
<td>Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments</td>
<td>090</td>
<td>RAW</td>
<td>Pre-Time Analysis</td>
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<td>14.38</td>
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<tr>
<td>25675</td>
<td>Closed treatment of distal radioulnar dislocation with manipulation</td>
<td>090</td>
<td>PE Subcommittee</td>
<td>Emergent Procedures</td>
<td>Yes</td>
<td>4.89</td>
<td>7.64</td>
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<td></td>
<td>PE Clinical staff pre-time revised</td>
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<tr>
<td>26020</td>
<td>Drainage of tendon sheath, digit and/or palm, each</td>
<td>090</td>
<td>Tendon Sheath Procedures</td>
<td>Negative IWPUT</td>
<td>Yes</td>
<td>6.84</td>
<td>NA</td>
<td>8.45</td>
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### RUC Recommendation:
- Most Recent RUC Meeting: September 2014
- Tab: 21
- Specialty Developing Recommendation: AAOS, ASSH
- First Identified: September 2014
- Medicare Utilization: 6,568
- 2022 Work RVU: 11.07
- 2022 NF PE RVU: NA
- 2022 Fac PE RVU: 11.36

- RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.
- Referred to CPT
- Result: Maintain
- Published in CPT Asst: Yes

### RUC Recommendation:
- Most Recent RUC Meeting: September 2014
- Tab: 21
- Specialty Developing Recommendation: AAOS, ASSH
- First Identified: January 2014
- Medicare Utilization: 17,635
- 2022 Work RVU: 14.38
- 2022 NF PE RVU: NA
- 2022 Fac PE RVU: 14.06

- RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.
- Referred to CPT
- Result: Maintain
- Published in CPT Asst: Yes

### RUC Recommendation:
- Most Recent RUC Meeting: April 2016
- Tab: 46
- Specialty Developing Recommendation: AAOS, ACEP, and orthopaedc subspecialties
- First Identified: October 2015
- Medicare Utilization: 421
- 2022 Work RVU: 4.89
- 2022 NF PE RVU: 7.64
- 2022 Fac PE RVU: 6.33

- RUC Recommendation: PE Clinical staff pre-time revised
- Referred to CPT
- Result: PE Only
- Published in CPT Asst: Jan 2018

### RUC Recommendation:
- Most Recent RUC Meeting: April 2018
- Tab: 07
- Specialty Developing Recommendation: AAOS, ASPS, ASSH
- First Identified: April 2017
- Medicare Utilization: 2,274
- 2022 Work RVU: 6.84
- 2022 NF PE RVU: NA
- 2022 Fac PE RVU: 8.45

- RUC Recommendation: 7.79
- Referred to CPT
- Result: Increase
- Published in CPT Asst: Yes

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Tuesday, February 1, 2022

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### 26055 Tendon Sheath Procedures

**Tendon sheath incision (eg, for trigger finger)**

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>090</td>
<td>Tender Sheath Procedures</td>
<td>Negative IWPUT</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** April 2018  
**Tab:** 07  
**Specialty Developing Recommendation:** AAOS, ASPS, ASSH  
**First Identified:** April 2017  
**2020 Medicare Utilization:** 91,853

**RUC Recommendation:** 3.75  
**Result:** Increase

**2022 Work RVU:** 3.11  
**2022 NF PE RVU:** 14.24  
**2022 Fac PE RVU:** 4.98

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

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### 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:** AAOS, ASSH  
**First Identified:** September 2007  
**2020 Medicare Utilization:** 1,617

**RUC Recommendation:** Action plan for RAW Oct 2015. Maintain  
**Referred to CPT**  
**Published in CPT Asst:** Sep 2012

**2022 Work RVU:** 4.47  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.60

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### 26160 Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger

**Global:** 090  
**Issue:** Tender 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  
**2020 Medicare Utilization:** 13,564

**RUC Recommendation:** 3.57  
**Result:** Maintain

**2022 Work RVU:** 3.57  
**2022 NF PE RVU:** 14.44  
**2022 Fac PE RVU:** 5.18

**Referred to CPT**  
**Published in CPT Asst:**
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<tr>
<td><strong>26356</strong> Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man’s land); primary, without free graft, each tendon</td>
<td>Repair Flexor Tendon</td>
<td>Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits</td>
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<td><strong>26357</strong> Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man’s land); secondary, without free graft, each tendon</td>
<td>Repair Flexor Tendon</td>
<td>090-Day Global Post-Operative Visits</td>
<td>Yes</td>
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<td><strong>26358</strong> 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</td>
<td>Repair Flexor Tendon</td>
<td>090-Day Global Post-Operative Visits</td>
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<tr>
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<th>First Identified</th>
<th>Medicare Utilization</th>
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<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<td>AAOS, ASPS, ASSH</td>
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Result: Decrease

Result: Increase

Result: Increase
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<td>26480</td>
<td>Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon</td>
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<td>Tendon Transfer</td>
<td>CMS Fastest Growing</td>
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<tr>
<td>26700</td>
<td>Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia</td>
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<td>PE Subcommittee</td>
<td>Emergent Procedures</td>
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<tr>
<td>26750</td>
<td>Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each</td>
<td>090</td>
<td>PE Subcommittee</td>
<td>Emergent Procedures</td>
<td>Yes</td>
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<td>26755</td>
<td>Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each</td>
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<td>Emergent Procedures</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
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<tr>
<td>26770</td>
<td>Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia</td>
<td>090</td>
<td>PE Subcommittee</td>
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<td><strong>RUC Meeting:</strong> April 2016</td>
<td><strong>Specialty Developing Recommendation:</strong> AAOS, ACEPT, and orthopaedic subspecialties</td>
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<td><strong>Medicare Utilization:</strong> 5,399</td>
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<td><strong>2022 NF PE RVU:</strong> 4.84</td>
<td><strong>2022 Fac PE RVU:</strong> 4.06</td>
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</tbody>
</table>

| 27048 | Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm | 090    | Excision of Subfascial Soft Tissue Tumor Codes | Site of Service Anomaly | Yes |
| **Most Recent** | **RUC Meeting:** February 2009 | **Specialty Developing Recommendation:** ACS, AAOS | **First Identified:** September 2007 | **Medicare Utilization:** 316 | **2022 Work RVU:** 8.85 |
| | | | | | **2022 NF PE RVU:** NA |
| | | | | | **2022 Fac PE RVU:** 7.34 |
| | | | | | **Result:** Increase |
| | | | | | **Referred to CPT Asst Published in CPT Asst:** |

| 27062 | Excision; trochanteric bursa or calcification | 090    | Trochanteric Bursa Excision | Site of Service Anomaly | Yes |
| **Most Recent** | **RUC Meeting:** April 2008 | **Specialty Developing Recommendation:** AAOS | **First Identified:** September 2007 | **Medicare Utilization:** 1,733 | **2022 Work RVU:** 5.75 |
| | | | | | **2022 NF PE RVU:** NA |
| | | | | | **2022 Fac PE RVU:** 6.68 |
| | | | | | **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 | 000    | Injection for Sacroiliac Joint | Different Performing Specialty from Survey | Yes |
| **Most Recent** | **RUC Meeting:** April 2011 | **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS | **First Identified:** October 2009 | **Medicare Utilization:** 399,563 | **2022 Work RVU:** 1.48 |
| | | | | | **2022 NF PE RVU:** 3.25 |
| | | | | | **2022 Fac PE RVU:** 0.81 |
| | | | | | **Result:** Decrease |
| | | | | | **Referred to CPT Asst Published in CPT Asst:** |
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>090</td>
<td>Hip/Knee Arthroplasty</td>
<td>CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019</td>
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<td>2020 Medicare Utilization: 146,584</td>
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<td>27134</td>
<td>Revision of total hip arthroplasty; both components, with or without autograft or allograft</td>
<td>090</td>
<td>RAW</td>
<td>Pre-Time Analysis</td>
<td>Yes</td>
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<td>2020 Medicare Utilization: 9,978</td>
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<td>27193</td>
<td>Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation</td>
<td>090</td>
<td>Closed Treatment of Pelvic Ring Fracture</td>
<td>CMS Request - Final Rule for 2014</td>
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<th>27194</th>
<th>Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia</th>
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<th>27197</th>
<th>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</th>
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<tr>
<th>27198</th>
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<th>Global: 000</th>
<th>Issue: Closed Treatment of Pelvic Ring Fracture</th>
<th>Screen: CMS Request - Final Rule for 2014</th>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>27220</td>
<td>Closed treatment of acetabulum (hip socket) fracture(s); without manipulation</td>
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<td>Closed treatment of femoral fracture, proximal end, neck; without manipulation</td>
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<td>Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction</td>
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| 27244  | Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage | 090    | Treat Thigh Fracture | High IWPUT             | Yes       | 18.18         | NA             | 14.47           |
|        | Most Recent RUC Meeting: October 2008                                        |        |                |                         |           |               |                |                 |
|        | Tab: 12                                                                      |        |                |                         |           |               |                |                 |
|        | Specialty Developing Recommendation: AAOS                                     |        |                |                         |           |               |                |                 |
|        | First Identified: April 2008                                                 |        |                |                         |           |               |                |                 |
|        | RUC Recommendation: 18.00                                                     |        |                |                         |           |               |                |                 |
|        | Referred to CPT                                                             |        |                |                         |           |               |                |                 |
|        | Referred to CPT Asst                                                          |        |                |                         |           |               |                |                 |
|        | Published in CPT Asst                                                        |        |                |                         |           |               |                |                 |
|        | Result: Increase                                                             |        |                |                         |           |               |                |                 |

| 27245  | Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage | 090    | Treat Thigh Fracture | High IWPUT / CMS Fastest Growing | Yes       | 18.18         | NA             | 14.46           |
|        | Most Recent RUC Meeting: October 2008                                        |        |                |                         |           |               |                |                 |
|        | Tab: 12                                                                      |        |                |                         |           |               |                |                 |
|        | Specialty Developing Recommendation: AAOS                                     |        |                |                         |           |               |                |                 |
|        | First Identified: February 2008                                              |        |                |                         |           |               |                |                 |
|        | RUC Recommendation: 18.00                                                     |        |                |                         |           |               |                |                 |
|        | Referred to CPT                                                             |        |                |                         |           |               |                |                 |
|        | Referred to CPT Asst                                                          |        |                |                         |           |               |                |                 |
|        | Published in CPT Asst                                                        |        |                |                         |           |               |                |                 |
|        | Result: Decrease                                                             |        |                |                         |           |               |                |                 |

| 27250  | Closed treatment of hip dislocation, traumatic; without anesthesia            | 000    | Closed Treatment of Hip Dislocation | Site of Service Anomaly | Yes       | 3.82          | NA             | 0.73            |
|        | Most Recent RUC Meeting: February 2008                                       |        |                |                         |           |               |                |                 |
|        | Tab: 18                                                                      |        |                |                         |           |               |                |                 |
|        | Specialty Developing Recommendation: ACEP                                      |        |                |                         |           |               |                |                 |
|        | First Identified: September 2007                                             |        |                |                         |           |               |                |                 |
|        | RUC Recommendation: 3.82                                                      |        |                |                         |           |               |                |                 |
|        | Referred to CPT                                                             |        |                |                         |           |               |                |                 |
|        | Referred to CPT Asst                                                          |        |                |                         |           |               |                |                 |
|        | Published in CPT Asst                                                        |        |                |                         |           |               |                |                 |
|        | Result: Decrease                                                             |        |                |                         |           |               |                |                 |
# Status Report: CMS Requests and Relativity Assessment Issues

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| 27265        | Closed treatment of post hip arthroplasty dislocation; without anesthesia    | 090    | PE Subcommittee | Emergent Procedures | Yes |
|              | **Most Recent RUC Meeting:** April 2016                                      |        |       |        |           |
|              | **Tab:** 46                                                                  |        |       |        |           |
|              | **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties |        |       |        |           |
|              | **First Identified:** October 2015                                           |        |       |        |           |
|              | **Medicare Utilization:** 2020                                               | 7,736  |       |        |           |
|              | **2022 Work RVU:** 5.24                                                      |        |       |        |           |
|              | **2022 NF PE RVU:** NA                                                       |        |       |        |           |
|              | **2022 Fac PE RVU:** 5.97                                                    |        |       |        |           |
|              | **RUC Recommendation:** PE Clinical staff pre-time revised                  |        |       |        |           |
|              | **Refer to CPT**                                                             |        |       |        |           |
|              | **Refer to CPT Asst**                                                        |        |       |        |           |
|              | **Published in CPT Asst:**                                                   |        |       |        |           |
|              | **Result:** PE Only                                                          |        |       |        |           |

| 27266        | Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia | 090    | PE Subcommittee | Emergent Procedures | Yes |
|              | **Most Recent RUC Meeting:** April 2016                                      |        |       |        |           |
|              | **Tab:** 46                                                                  |        |       |        |           |
|              | **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties |        |       |        |           |
|              | **First Identified:** October 2015                                           |        |       |        |           |
|              | **Medicare Utilization:** 2020                                               | 5,027  |       |        |           |
|              | **2022 Work RVU:** 7.78                                                      |        |       |        |           |
|              | **2022 NF PE RVU:** NA                                                       |        |       |        |           |
|              | **2022 Fac PE RVU:** 8.09                                                    |        |       |        |           |
|              | **RUC Recommendation:** PE Clinical staff pre-time revised                  |        |       |        |           |
|              | **Refer to CPT**                                                             |        |       |        |           |
|              | **Refer to CPT Asst**                                                        |        |       |        |           |
|              | **Published in CPT Asst:**                                                   |        |       |        |           |
|              | **Result:** PE Only                                                          |        |       |        |           |

| 27279        | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device | 090    | Arthrodesis - Sacroiliac Joint | CMS Request - Final Rule for 2018 | Yes |
|              | **Most Recent RUC Meeting:** April 2018                                      |        |       |        |           |
|              | **Tab:** 09                                                                  |        |       |        |           |
|              | **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS         |        |       |        |           |
|              | **First Identified:** July 2017                                              |        |       |        |           |
|              | **Medicare Utilization:** 2020                                               | 4,778  |       |        |           |
|              | **2022 Work RVU:** 12.13                                                     |        |       |        |           |
|              | **2022 NF PE RVU:** NA                                                       |        |       |        |           |
|              | **2022 Fac PE RVU:** 9.89                                                    |        |       |        |           |
|              | **RUC Recommendation:** 9.03                                                  |        |       |        |           |
|              | **Refer to CPT**                                                             |        |       |        |           |
|              | **Refer to CPT Asst**                                                        |        |       |        |           |
|              | **Published in CPT Asst:**                                                   |        |       |        |           |
|              | **Result:** Maintain                                                         |        |       |        |           |
## Status Report: CMS Requests and Relativity Assessment Issues

### 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

**RUC Recommendation:** Reduce 99238 to 0.5

**Result:** PE Only

---

### 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

**RUC Recommendation:** 0.96

**Result:** Maintain

---

### 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

**RUC Recommendation:** Deleted from CPT

**Result:** Deleted from CPT

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Tuesday, February 1, 2022
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<td>Arthroplasty, knee, condyle and plateau; medial or lateral compartment</td>
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<td>Knee Arthroplasty</td>
<td>Yes</td>
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<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
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<td>Hip/Knee Arthroplasty</td>
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<td>CMS High Expenditure Procedural Codes / CMS Request - Final Rule for 2019</td>
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**Notes:**
- Tab: 18
- Specialty Developing Recommendation: AAOS, AAHKS
- First Identified: September 2011
- 2020 Medicare Utilization:
  - 2022 Work RVU: 17.48
  - 2022 NF PE RVU: NA
  - 2022 Fac PE RVU: 13.13
- RUC Recommendation: 17.13
- Referred to CPT
- Published in CPT Asst: No
- Referred to CPT Asst:

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**Tuesday, February 1, 2022**
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<tr>
<td>27615</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm</td>
<td>090</td>
<td>Radical Resection of Soft Tissue Tumor Codes</td>
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<td>RUC Recommendation: 15.54</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>27619</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>090</td>
<td>Excision of Subfascial Soft Tissue Tumor Codes</td>
<td>RUC Recommendation: 6.80</td>
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- **Most Recent RUC Meeting:** February 2009
- **Screen:** Site of Service Anomaly
- **Tab:** 5
- **First Identified:** September 2007
- **Medicare Utilization:** 2020: 463
- **2022 Work RVU:** 6.91
- **2022 NF PE RVU:** 2022: NA
- **2022 Fac PE RVU:** 5.66
- **Result:** Decrease

### 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
- **Medicare Utilization:** 2020: 1,640
- **2022 Work RVU:** 12.24
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 10.24
- **Result:** Maintain

### 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
- **Medicare Utilization:** 2020: 985
- **2022 Work RVU:** 9.84
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 7.91
- **Result:** Decrease

### 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
- **Medicare Utilization:** 2020: 2,064
- **2022 Work RVU:** 9.21
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 8.90
- **Result:** Decrease
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<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<tbody>
<tr>
<td><strong>27654</strong>     Repair, secondary, achilles tendon, with or without graft</td>
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<td>Global: 090    Issue: Achilles Tendon Repair</td>
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<tr>
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<tr>
<td>Tab: 33 Specialty Developing Recommendation: AOFAS, APMA, AAOS</td>
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<td>First Identified: September 2007</td>
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<td>2020 Medicare Utilization: 2,734</td>
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<td>2022 Fac PE RVU: 9.03</td>
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<td>RUC Recommendation: 10.32</td>
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<tr>
<td>Published in CPT Asst:</td>
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<td>Result: Maintain</td>
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</tbody>
</table>

| **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                     |
| 2020 Medicare Utilization: 3,677                     |
| 2022 Work RVU: 6.69                                  |
| 2022 NF PE RVU: 11.90                               |
| 2022 Fac PE RVU: 6.13                               |
| RUC Recommendation: Reduce 99238 to 0.5              |
| Referred to CPT                                      |
| Published in CPT Asst:                               |
| Result: PE Only                                     |

| **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                     |
| 2020 Medicare Utilization: 5,972                     |
| 2022 Work RVU: 6.41                                  |
| 2022 NF PE RVU: NA                                  |
| 2022 Fac PE RVU: 6.09                               |
| RUC Recommendation: Reduce 99238 to 0.5              |
| Referred to CPT                                      |
| Published in CPT Asst:                               |
| Result: PE Only                                     |

| **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                     |
| 2020 Medicare Utilization: 1,109                     |
| 2022 Work RVU: 9.17                                  |
| 2022 NF PE RVU: NA                                  |
| 2022 Fac PE RVU: 8.46                               |
| RUC Recommendation: 8.96                            |
| Referred to CPT                                      |
| Published in CPT Asst:                               |
| Result: Maintain                                    |
## 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

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: April 2008</th>
<th>Tab: 34</th>
<th>Specialty Developing Recommendation: AOFAS, APMA, AAOS</th>
<th>First Identified: September 2007</th>
<th>Medicare Utilization: 3,911</th>
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<tr>
<td>RUC Recommendation: 10.28</td>
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</table>

- **RUC Recommendation:** 2022 Work RVU: 10.49  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 9.81

- **Result:** Maintain  
- **Referred to CPT**  
- **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

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<tbody>
<tr>
<td>RUC Recommendation: PE Clinical staff pre-time revised</td>
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</tbody>
</table>

- **RUC Recommendation:** 2022 Work RVU: 6.27  
- **2022 NF PE RVU:** 8.51  
- **2022 Fac PE RVU:** 7.15

- **Result:** PE Only  
- **Referred to CPT**  
- **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

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<tbody>
<tr>
<td>RUC Recommendation: PE Clinical staff pre-time revised</td>
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</tbody>
</table>

- **RUC Recommendation:** 2022 Work RVU: 5.47  
- **2022 NF PE RVU:** 7.93  
- **2022 Fac PE RVU:** 6.56

- **Result:** PE Only  
- **Referred to CPT**  
- **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

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<th>Issue</th>
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<tbody>
<tr>
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<td>Site of Service Anomaly</td>
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</table>

**Most Recent RUC Meeting:** February 2011  
**Tab:** 18  
**Specialty Developing Recommendation:** AAOS, AOFAS,  
**First Identified:** June 2010  
**2020 Medicare Utilization:** 6,531  
**2022 Work RVU:** 8.75  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 8.83  
**Complete?** Yes  

- **RUC Recommendation:** 9.71  
- **Result:** Maintain  
- **Referred to CPT**  
- **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

<table>
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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
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<td>Emergent Procedures</td>
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**Most Recent RUC Meeting:** April 2016  
**Tab:** 46  
**Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 2,798  
**2022 Work RVU:** 5.32  
**2022 NF PE RVU:** 7.79  
**2022 Fac PE RVU:** 6.39  
**Complete?** Yes  

- **RUC Recommendation:** PE Clinical staff pre-time revised  
- **Result:** PE Only  
- **Referred to CPT**  
- **Published in CPT Asst:**

#### 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

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<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
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<tr>
<td>090</td>
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**Most Recent RUC Meeting:** September 2014  
**Tab:** 21  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** January 2014  
**2020 Medicare Utilization:** 10,116  
**2022 Work RVU:** 10.62  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 10.07  
**Complete?** Yes  

- **RUC Recommendation:** Maintain work RVU and adjust the times from pre-time package 3.  
- **Result:** Maintain  
- **Referred to CPT**  
- **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 (90238-Only) / Emergent Procedures
- **Complete?** Yes

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<tr>
<th>2022 Work RVU:</th>
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<tbody>
<tr>
<td>2022 NF PE RVU:</td>
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<td>2022 Fac PE RVU:</td>
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<td>Tab:</td>
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### 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

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<th>2022 Work RVU:</th>
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<td>2022 NF PE RVU:</td>
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### 27840

- **Closed treatment of ankle dislocation; without anesthesia**
- **Global:** 090  
  **Issue:** PE Subcommittee  
  **Screen:** Emergent Procedures
- **Complete?** Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>28001</th>
<th>Incision and drainage, bursa, foot</th>
<th>Global: 010</th>
<th>Issue: Treatment of Foot Infection</th>
<th>Screen: 010-Day Global Post-Operative Visits2</th>
<th>Complete?</th>
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<td><strong>Specialty Developing Recommendation:</strong> AAOS, AOFAS, APMA</td>
<td><strong>First Identified:</strong> April 2020</td>
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<td>28002</td>
<td>Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space</td>
<td>Global: 010</td>
<td>Issue: Treatment of Foot Infection</td>
<td>Screen: 010-Day Global Post-Operative Visits2</td>
<td>Complete?</td>
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<td><strong>Most Recent RUC Meeting:</strong></td>
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<tr>
<td>28003</td>
<td>Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas</td>
<td>Global: 090</td>
<td>Issue: Treatment of Foot Infection</td>
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<td>Complete?</td>
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<td>28111</td>
<td>Ostectomy, complete excision; first metatarsal head</td>
<td>Global: 090</td>
<td>Issue: Ostectomy</td>
<td>Screen: Site of Service Anomaly (99238-Only)</td>
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<td><strong>Most Recent RUC Meeting:</strong></td>
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<td><strong>Tab:</strong> 16</td>
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<td><strong>First Identified:</strong> September 2007</td>
<td><strong>2020 Medicare Utilization:</strong> 1,064</td>
<td><strong>2022 Work RVU:</strong> 5.15</td>
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<td><strong>RUC Recommendation:</strong></td>
<td>Reduce 99238 to 0.5</td>
<td><strong>Referred to CPT</strong></td>
<td><strong>Published in CPT Asst:</strong></td>
<td><strong>Result:</strong> PE Only</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Global</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>Partial excision (craterization, saucerization, sequestrectomy, or</td>
<td>090</td>
<td>Site of Service Anomaly</td>
<td>Yes</td>
</tr>
<tr>
<td>diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Most Recent RUC Meeting: February 2011</td>
<td>Tab: 19</td>
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<td>Published in CPT Asst</td>
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<td>2022 Fac PE RVU: 6.38</td>
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<td>Result: Increase</td>
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</tbody>
</table>

| Partial excision (craterization, saucerization, sequestrectomy, or    | 090    | Site of Service Anomaly | Yes       |
| diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or         |        |                 |           |
| metatarsal bone, except talus or calcaneus                            |        |                 |           |
| Most Recent RUC Meeting: February 2011                                | Tab: 19| Specialty Developing Recommendation: AOFAS, APMA, AAOS |           |
| First Identified: September 2007                                      |        | 2020 Medicare Utilization: 14,389 |           |
| RUC Recommendation: 7.72                                              |        | 2022 Work RVU: 6.76 |           |
| Referred to CPT                                                       |        | 2022 NF PE RVU: 9.96 |           |
| Published in CPT Asst                                                |        | 2022 Fac PE RVU: 5.38 |           |
| Result: Maintain                                                      |        |                 |           |

| Partial excision (craterization, saucerization, sequestrectomy, or    | 090    | Site of Service Anomaly | Yes       |
| diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe    |        |                 |           |
| Most Recent RUC Meeting: September 2007                               | Tab: 16| Specialty Developing Recommendation: APMA, AAOS |           |
| First Identified: September 2007                                      |        | 2020 Medicare Utilization: 9,041 |           |
| RUC Recommendation: Remove 99238                                     |        | 2022 Work RVU: 5.00 |           |
| Referred to CPT                                                       |        | 2022 NF PE RVU: 8.61 |           |
| Published in CPT Asst                                                |        | 2022 Fac PE RVU: 4.33 |           |
| Result: PE Only                                                       |        |                 |           |

<p>| Correction, hammertoe (eg, interphalangeal fusion, partial or total    | 090    | Harvard Valued - Utilization over 30,000 | Yes       |
| phalanectomy)                                                        |        |                                             |           |
| Most Recent RUC Meeting: October 2010                                 | Tab: 31| Specialty Developing Recommendation: AAOS, AOFAS, APMA |           |
| First Identified: February 2010                                      |        | 2020 Medicare Utilization: 54,045 |           |
| RUC Recommendation: 5.62                                              |        | 2022 Work RVU: 5.62 |           |
| Referred to CPT                                                       |        | 2022 NF PE RVU: 9.64 |           |
| Published in CPT Asst                                                |        | 2022 Fac PE RVU: 5.06 |           |
| Result: Increase                                                      |        |                 |           |</p>
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### 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

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**Most Recent RUC Meeting:** January 2016  
**Tab:** 08  
**Specialty Developing Recommendation:** AAOS, AOFAS, APMA  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 4,884  
**2022 Work RVU:** 7.44  
**2022 NF PE RVU:** 12.34  
**2022 Fac PE RVU:** 5.96  
**Result:** Decrease

Refer to CPT: October 2015

Refer to CPT Asst: Published in CPT Asst:

#### 28293 - Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant

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**Most Recent RUC Meeting:** January 2016  
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**First Identified:** January 2014  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Result:** Deleted from CPT

Refer to CPT: October 2015

Refer to CPT Asst: Published in CPT Asst:

#### 28294 - Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)

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**First Identified:** October 2015  
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**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Result:** Deleted from CPT

Refer to CPT: October 2015

Refer to CPT Asst: Published in CPT Asst:
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>2022 Fac PE RVU</th>
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### Status Report: CMS Requests and Relativity Assessment Issues

**28299 Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method**

- **Global:** 090  
- **Issue:** Bunionectomy

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**RUC Recommendation:** 9.29  
**Referred to CPT:** October 2015  
**Result:** Decrease

**Screen:** 90-Day Global Post-Operative Visits

- **2022 Work RVU:** 9.29  
- **2022 NF PE RVU:** 19.57  
- **2022 Fac PE RVU:** 6.99

**28300 Osteotomy; calcaneus (eg, dwyer or chambers type procedure), with or without internal fixation**

- **Global:** 090  
- **Issue:** Osteotomy

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**RUC Recommendation:** Reduce 99238 to 0.5  
**Referred to CPT**  
**Published in CPT Asst:**

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

- **2022 Work RVU:** 9.73  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 7.95

**28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)**

- **Global:** 090  
- **Issue:** Osteotomy

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**RUC Recommendation:** Reduce 99238 to 0.5  
**Referred to CPT**  
**Published in CPT Asst:**

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

- **2022 Work RVU:** 5.57  
- **2022 NF PE RVU:** 9.92  
- **2022 Fac PE RVU:** 4.44

**28470 Closed treatment of metatarsal fracture; without manipulation, each**

- **Global:** 090  
- **Issue:** Treatment of Metatarsal Fracture

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**RUC Recommendation:** 2.03  
**Referred to CPT**  
**Published in CPT Asst:**

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

- **2022 Work RVU:** 2.03  
- **2022 NF PE RVU:** 4.19  
- **2022 Fac PE RVU:** 3.80

**Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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# Status Report: CMS Requests and Relativity Assessment Issues

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<td>29445 Application of rigid total contact leg cast</td>
<td>AAOS, AHKNS, AOFAS, AOA, NASS</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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| 29550 | Strapping; toes                                  | 000    | Strapping Lower Extremity | Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M | Yes       |
|       |                                                  |        |                     |                                             |           |
|       | Most Recent RUC Meeting: April 2017              |        |                     |                                             |           |
|       | Tab: 41ii Specialty Developing Recommendation: A |        |                     |                                             |           |
|       | RUC Recommendation: 0.25                         |        |                     |                                             |           |
|       | First Identified: February 2010                  |        |                     |                                             |           |
|       | 2020 Medicare Utilization: 44,200                 |        |                     |                                             |           |
|       | 2022 Work RVU: 0.25                              |        |                     |                                             |           |
|       | 2022 NF PE RVU: 0.29                             |        |                     |                                             |           |
|       | 2022 Fac PE RVU: 0.06                            |        |                     |                                             |           |
|       | Result: Decrease                                 |        |                     |                                             |           |
|       | Referred to CPT                                  |        |                     |                                             |           |
|       | Referred to CPT Asst                             |        |                     |                                             |           |
|       | Published in CPT Asst                            |        |                     |                                             |           |

| 29580 | Strapping; unna boot                             | 000    | Strapping Multi Layer Compression | CMS High Expenditure Procedural Codes2 | Yes       |
|       |                                                  |        |                     |                                             |           |
|       | Most Recent RUC Meeting: October 2016            |        |                     |                                             |           |
|       | Tab: 13 Specialty Developing Recommendation: A, ACS, APMA, SVS |        |                     |                                             |           |
|       | RUC Recommendation: 0.55                         |        |                     |                                             |           |
|       | First Identified: July 2015                      |        |                     |                                             |           |
|       | 2020 Medicare Utilization: 231,247                |        |                     |                                             |           |
|       | 2022 Work RVU: 0.55                              |        |                     |                                             |           |
|       | 2022 NF PE RVU: 1.27                             |        |                     |                                             |           |
|       | 2022 Fac PE RVU: 0.16                            |        |                     |                                             |           |
|       | Result: Maintain                                 |        |                     |                                             |           |
|       | Referred to CPT                                  |        |                     |                                             |           |
|       | Referred to CPT Asst                             |        |                     |                                             |           |
|       | Published in CPT Asst                            |        |                     |                                             |           |
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Screen:</th>
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<tbody>
<tr>
<td>29581</td>
<td>Application of multi-layer compression system; leg (below knee), including ankle and foot</td>
<td>000</td>
<td>Strapping Multi Layer Compression</td>
<td>Yes</td>
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<tr>
<td>29582</td>
<td>Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed</td>
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<td>New Technology Review</td>
<td>Yes</td>
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<tr>
<td>29583</td>
<td>Application of multi-layer compression system; upper arm and forearm</td>
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<td>New Technology Review</td>
<td>Yes</td>
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### 29581 Application of multi-layer compression system; leg (below knee), including ankle and foot

**Most Recent RUC Meeting:** October 2016  
**Tab:** 13  
**Specialty Developing Recommendation:** ACS, APMA, SVS  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 184,476  
**Result:** Maintain

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

**Screen:** CMS High Expenditure Procedural Codes2

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<td>2022 Fac PE RVU</td>
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### 29582 Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed

**Most Recent RUC Meeting:** October 2015  
**Tab:** 21  
**Specialty Developing Recommendation:** APTA  
**First Identified:** October 2015  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT  
**Referred to CPT**  
**Published in CPT Asst:** Aug 2016

### 29583 Application of multi-layer compression system; upper arm and forearm

**Most Recent RUC Meeting:** October 2015  
**Tab:** 21  
**Specialty Developing Recommendation:** APTA  
**First Identified:** October 2015  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT  
**Referred to CPT**  
**Published in CPT Asst:** Aug 2016

---

**Screen:** New Technology/New Services
## 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?** Yes

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- **First Identified:** October 2015
- **2020 Medicare Utilization:** 1,728

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<td>Published in CPT Asst:</td>
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#### 2022 Work RVU: 0.35
#### 2022 NF PE RVU: 2.10
#### 2022 Fac PE RVU: 0.10

### 29590 Denis-Browne splint strapping

- **Global:** 2090
- **Issue:** Dennis-Browne splint revision
- **Screen:** Harvard Valued - Utilization over 100,000
- **Complete?** Yes

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- **First Identified:** February 2010
- **2020 Medicare Utilization:**

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#### 2022 Work RVU:
#### 2022 NF PE RVU:
#### 2022 Fac PE RVU:

### 29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

- **Global:** 090
- **Issue:** Arthroscopy
- **Screen:** CMS Request - Practice Expense Review
- **Complete?** Yes

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<td>51</td>
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- **First Identified:** NA
- **2020 Medicare Utilization:** 444

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<th>First Identified</th>
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<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
<th>Result</th>
<th>Referral Notes</th>
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<td>29822</td>
<td>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])</td>
<td>090</td>
<td>Shoulder Debridement</td>
<td>CMS Fastest Growing</td>
<td>Yes</td>
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<tr>
<td>29823</td>
<td>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])</td>
<td>090</td>
<td>Shoulder Debridement</td>
<td>Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization over 30,000-Part3</td>
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<td>Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (mumford procedure)</td>
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</table>
# 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)

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## 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair

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## 29828 Arthroscopy, shoulder, surgical; biceps tenodesis

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>29830</td>
<td>Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)</td>
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<td>Arthroscopy</td>
<td>CMS Request - Practice Expense Review</td>
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**Most Recent RUC Meeting:** April 2008  
**Tab:** 51  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** NA  
**2020 Medicare Utilization:** 108  
**Complete?** Yes  
**2022 Work RVU:** 5.88  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.62  
**Refer to CPT:** Refered to CPT Asst  
**Published in CPT Asst:** Yes

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<td>Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)</td>
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<td>Arthroscopy</td>
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**Most Recent RUC Meeting:** April 2008  
**Tab:** 51  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** NA  
**2020 Medicare Utilization:** 135  
**Complete?** Yes  
**2022 Work RVU:** 5.68  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.72  
**Refer to CPT:** Refered to CPT Asst  
**Published in CPT Asst:** Yes

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**Most Recent RUC Meeting:** October 2009  
**Tab:** 13  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** NA  
**2020 Medicare Utilization:** 693  
**Complete?** Yes  
**2022 Work RVU:** 5.19  
**2022 NF PE RVU:** 10.33  
**2022 Fac PE RVU:** 5.94  
**Refer to CPT:** Refered to CPT Asst  
**Published in CPT Asst:** Yes

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<td>29888</td>
<td>Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction</td>
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<td>ACL Repair</td>
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**Most Recent RUC Meeting:** April 2008  
**Tab:** 38  
**Specialty Developing Recommendation:** AAOS  
**First Identified:** September 2007  
**2020 Medicare Utilization:** 1,016  
**Complete?** Yes  
**2022 Work RVU:** 14.30  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 11.89  
**Refer to CPT:** Refered to CPT Asst  
**Published in CPT Asst:** Yes

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>30140</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
<td>000</td>
<td>Resection of Inferior Turbinate</td>
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<td>30465</td>
<td>Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)</td>
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<td>Repair Nasal Stenosis</td>
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<td>30901</td>
<td>Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method</td>
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<td>Control Nasal Hemorrhage</td>
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<tr>
<td>30905</td>
<td>Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial</td>
<td>000</td>
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<td>CMS Request - Final Rule for 2016</td>
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**Most Recent RUC Meeting:** April 2016  
**Tab:** 20  
**Specialty Developing Recommendation:** AAOHNS  
**First Identified:**  
- 30901: October 2009  
- 30903: July 2015  
- 30905: July 2015  
**2020 Medicare Utilization:**  
- 30901: 70,328  
- 30903: 39,728  
- 30905: 4,585  
**2022 Work RVU:**  
- 30901: 1.10  
- 30903: 1.54  
- 30905: 1.97  
**2022 NF PE RVU:**  
- 30901: 3.47  
- 30903: 5.66  
- 30905: 8.35  
**2022 Fac PE RVU:**  
- 30901: 0.38  
- 30903: 0.48  
- 30905: 0.80  
**Result:** Maintain
**Status Report: CMS Requests and Relativity Assessment Issues**

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| 31231            | Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)    | 000    | Nasal/Sinus Endoscopy | MPC List | Yes       |
|                  |                                                                             |        |       |        |           |           |
| **Most Recent**  |                                                                             |        |       |        |           |           |
| **RUC Meeting:** |                                                                             |        |       |        |           |           |
| January 2012     |                                                                             |        |       |        |           |           |
| **Tab:** 19      |                                                                             |        |       |        |           |           |
| Specialty Developing |                                                                             |        |       |        |           |           |
| AAO-HNS          |                                                                             |        |       |        |           |           |
| **First Identified:** |                                                                             |        |       |        |           |           |
| October 2010     |                                                                             |        |       |        |           |           |
| **2020 Medicare Utilization:** |                                                                             |        |       |        |           |           |
| 476,427          |                                                                             |        |       |        |           |           |
| **2022 Work RVU:** |                                                                             |        |       |        |           |           |
| 1.10             |                                                                             |        |       |        |           |           |
| **2022 NF PE RVU:** |                                                                             |        |       |        |           |           |
| 4.42             |                                                                             |        |       |        |           |           |
| **2022 Fac PE RVU:** |                                                                             |        |       |        |           |           |
| 0.63             |                                                                             |        |       |        |           |           |
| RUC Recommendation: | 1.10                                                                         |        |       |        |           |           |
| Referred to CPT |                                                                             |        |       |        |           |           |
| Referred to CPT Asst |                                                                             |        |       |        |           |           |
| Published in CPT Asst: | |        |       |        |           |           |
| Result: Maintain |                                                                             |        |       |        |           |           |

| 31237            | Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) | 000    | Nasal/Sinus Endoscopy | CMS High Expenditure Procedural Codes1 | Yes       |
|                  |                                                                             |        |       |        |           |           |
| **Most Recent**  |                                                                             |        |       |        |           |           |
| **RUC Meeting:** |                                                                             |        |       |        |           |           |
| April 2013       |                                                                             |        |       |        |           |           |
| **Tab:** 19      |                                                                             |        |       |        |           |           |
| Specialty Developing |                                                                             |        |       |        |           |           |
| AAO-HNS          |                                                                             |        |       |        |           |           |
| **First Identified:** |                                                                             |        |       |        |           |           |
| September 2011   |                                                                             |        |       |        |           |           |
| **2020 Medicare Utilization:** |                                                                             |        |       |        |           |           |
| 105,242          |                                                                             |        |       |        |           |           |
| **2022 Work RVU:** |                                                                             |        |       |        |           |           |
| 2.60             |                                                                             |        |       |        |           |           |
| **2022 NF PE RVU:** |                                                                             |        |       |        |           |           |
| 4.66             |                                                                             |        |       |        |           |           |
| **2022 Fac PE RVU:** |                                                                             |        |       |        |           |           |
| 1.71             |                                                                             |        |       |        |           |           |
| RUC Recommendation: | 2.60                                                                         |        |       |        |           |           |
| Referred to CPT |                                                                             |        |       |        |           |           |
| Referred to CPT Asst |                                                                             |        |       |        |           |           |
| Published in CPT Asst: | |        |       |        |           |           |
| Result: Decrease |                                                                             |        |       |        |           |           |

| 31238            | Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage            | 000    | Nasal/Sinus Endoscopy | CMS High Expenditure Procedural Codes1 | Yes       |
|                  |                                                                             |        |       |        |           |           |
| **Most Recent**  |                                                                             |        |       |        |           |           |
| **RUC Meeting:** |                                                                             |        |       |        |           |           |
| April 2013       |                                                                             |        |       |        |           |           |
| **Tab:** 19      |                                                                             |        |       |        |           |           |
| Specialty Developing |                                                                             |        |       |        |           |           |
| AAO-HNS          |                                                                             |        |       |        |           |           |
| **First Identified:** |                                                                             |        |       |        |           |           |
| January 2012     |                                                                             |        |       |        |           |           |
| **2020 Medicare Utilization:** |                                                                             |        |       |        |           |           |
| 23,984           |                                                                             |        |       |        |           |           |
| **2022 Work RVU:** |                                                                             |        |       |        |           |           |
| 2.74             |                                                                             |        |       |        |           |           |
| **2022 NF PE RVU:** |                                                                             |        |       |        |           |           |
| 4.32             |                                                                             |        |       |        |           |           |
| **2022 Fac PE RVU:** |                                                                             |        |       |        |           |           |
| 1.77             |                                                                             |        |       |        |           |           |
| RUC Recommendation: | 2.74                                                                         |        |       |        |           |           |
| Referred to CPT |                                                                             |        |       |        |           |           |
| Referred to CPT Asst |                                                                             |        |       |        |           |           |
| Published in CPT Asst: | |        |       |        |           |           |
| Result: Decrease |                                                                             |        |       |        |           |           |
### Status Report: CMS Requests and Relativity Assessment Issues

#### 31239 Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

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- **Most Recent RUC Meeting:** April 2013  
- **Tab:** 19  
- **Specialty Developing Recommendation:** AAO-HNS  
- **First Identified:** January 2012  
- **2020 Medicare Utilization:** 1.012  
- **2022 Work RVU:** 9.04  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 7.90  
- **Reflected to CPT:** 9.04  
- **Referred to CPT Asst:** Yes  
- **Published in CPT Asst:**  
- **Result:** Decrease

#### 31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection

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- **2020 Medicare Utilization:** 3.630  
- **2022 Work RVU:** 2.61  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 1.67  
- **Reflected to CPT:** 2.61  
- **Referred to CPT Asst:** Yes  
- **Published in CPT Asst:**  
- **Result:** Maintain

#### 31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery

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- **Most Recent RUC Meeting:** January 2017  
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- **Specialty Developing Recommendation:** AAOHNs  
- **First Identified:** April 2015  
- **2020 Medicare Utilization:** 397  
- **2022 Work RVU:** 8.00  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 3.93  
- **Reflected to CPT:** 8.51  
- **September 2016**  
- **Referred to CPT Asst:** Yes  
- **Published in CPT Asst:**  
- **Result:** Decrease
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### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
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## 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**

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**RUC Recommendation:** 21.50

- **First Identified:** October 2015
- **Medicare Utilization:**
  - 2020: NA
  - 2022:
    - Work RVU: 21.50
    - NF PE RVU: NA
    - Fac PE RVU: 21.37

**Result:** Depressed

**Referred to CPT:** October 2015

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

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### 31552
**Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older**

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**RUC Recommendation:** 20.50

- **First Identified:** October 2015
- **Medicare Utilization:**
  - 2020: 12
  - 2022:
    - Work RVU: 20.50
    - NF PE RVU: NA
    - Fac PE RVU: 20.94

**Result:** Depressed

**Referred to CPT:** October 2015

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

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### 31553
**Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age**

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**RUC Recommendation:** 22.00

- **First Identified:** October 2015
- **Medicare Utilization:**
  - 2020: 1
  - 2022:
    - Work RVU: 22.00
    - NF PE RVU: NA
    - Fac PE RVU: 25.13

**Result:** Depressed

**Referred to CPT:** October 2015

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

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### 31554
**Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older**

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**RUC Recommendation:** 22.00

- **First Identified:** October 2015
- **Medicare Utilization:**
  - 2020: 17
  - 2022:
    - Work RVU: 22.00
    - NF PE RVU: NA
    - Fac PE RVU: 25.16

**Result:** Depressed

**Referred to CPT:** October 2015

**Referred to CPT Asst Published in CPT Asst:**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>includes tracheotomy, if performed</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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- **Most Recent RUC Meeting:** January 2016
- **Tab:** 09
- **Specialty Developing Recommendation:** AAO-HNS
- **First Identified:** January 2014

Referred to CPT October 2015
Referred to CPT Asst
Screen: 090-Day Global Post-Operative Visits

### 2022 Work RVU:
- 2022 NF PE RVU:

### 2022 Fac PE RVU:
- **2022 Work RVU:**
- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**

**Result:** Deleted from CPT

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- **Most Recent RUC Meeting:** January 2016
- **Tab:** 09
- **Specialty Developing Recommendation:** AAOHNS
- **First Identified:** October 2015

Referred to CPT October 2015
Referred to CPT Asst
Screen: 090-Day Global Post-Operative Visits

### 2022 Work RVU:
- **2022 NF PE RVU:**

### 2022 Fac PE RVU:
- **2022 Work RVU:** 13.56
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 17.33

**Result:** Decrease

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- **Most Recent RUC Meeting:** January 2016
- **Tab:** 09
- **Specialty Developing Recommendation:** AAOHNS
- **First Identified:** October 2015

Referred to CPT October 2015
Referred to CPT Asst
Screen: 090-Day Global Post-Operative Visits

### 2022 Work RVU:
- **2022 NF PE RVU:**

### 2022 Fac PE RVU:
- **2022 Work RVU:** 25.00
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 22.99

**Result:** Decrease

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- **Most Recent RUC Meeting:** April 2016
- **Tab:** 21
- **Specialty Developing Recommendation:** AAOHNS
- **First Identified:** July 2015

Referred to CPT
Referred to CPT Asst
Screen: CMS High Expenditure Procedural Codes2

### 2022 Work RVU:
- **2022 NF PE RVU:**

### 2022 Fac PE RVU:
- **2022 Work RVU:** 5.56
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.41

**Result:** Increase
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| 31603 | Tracheostomy, emergency procedure; transtracheal                       | 000    | Tracheostomy | CMS High Expenditure Procedural Codes2                                | Yes       | Increase |
|       | Most Recent RUC Meeting: April 2016                                    |        |       | Tab: 21  Specialty Developing Recommendation: AAOHNS                   |           |        |
|       | First Identified: July 2015                                            |        |       | 2020 Medicare Utilization: 740                                         |           |        |
|       | 2022 Work RVU: 6.00                                                   |        |       | 2022 NF PE RVU: NA                                                     |           |        |
|       | 2022 Fac PE RVU: 2.37                                                 |        |       | Result: Increase                                                       |           |        |
|       | RUC Recommendation: 6.00                                              |        |       | Published in CPT Asst:                                                |           |        |
|       | Referred to CPT                                                       |        |       |                                                                       |           |        |
|       | Referred to CPT Asst                                                  |        |       |                                                                       |           |        |

| 31605 | Tracheostomy, emergency procedure; cricothyroid membrane               | 000    | Tracheostomy | CMS High Expenditure Procedural Codes2                                | Yes       | Increase |
|       | Most Recent RUC Meeting: April 2016                                    |        |       | Tab: 21  Specialty Developing Recommendation: AAOHNS                   |           |        |
|       | First Identified: July 2015                                            |        |       | 2020 Medicare Utilization: 254                                         |           |        |
|       | 2022 Work RVU: 6.45                                                   |        |       | 2022 NF PE RVU: NA                                                     |           |        |
|       | 2022 Fac PE RVU: 2.07                                                 |        |       | Result: Increase                                                       |           |        |
|       | RUC Recommendation: 6.45                                              |        |       | Published in CPT Asst:                                                |           |        |
|       | Referred to CPT                                                       |        |       |                                                                       |           |        |
|       | Referred to CPT Asst                                                  |        |       |                                                                       |           |        |

| 31610 | Tracheostomy, fenestration procedure with skin flaps                   | 090    | Tracheostomy | CMS High Expenditure Procedural Codes2                                | Yes       | Increase |
|       | Most Recent RUC Meeting: October 2016                                  |        |       | Tab: 15  Specialty Developing Recommendation: AAOHNS, ACS             |           |        |
|       | First Identified: July 2015                                            |        |       | 2020 Medicare Utilization: 1,570                                      |           |        |
|       | 2022 Work RVU: 12.00                                                  |        |       | 2022 NF PE RVU: NA                                                     |           |        |
|       | 2022 Fac PE RVU: 14.85                                                 |        |       | Result: Increase                                                       |           |        |
|       | RUC Recommendation: 12.00                                              |        |       | Published in CPT Asst:                                                |           |        |
|       | Referred to CPT                                                       |        |       |                                                                       |           |        |
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### Status Report: CMS Requests and Relativity Assessment Issues

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| 31620  | Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or            | 05     | Endobronchial Ultrasound - EBUS   | High Volume Growth2            | Yes       |
|        | therapeutic intervention(s) (List separately in addition to code for primary  |        |                                    |                                  |           |
|        | procedure[s])                                                                 |        |                                    |                                  |           |
|        | **Most Recent RUC Meeting:** January 2015                                     |        |                                    |                                  |           |
|        | **Tab:** 05, **Specialty Developing Recommendation:** ACCP, ATS               |        |                                    |                                  |           |
|        | **First Identified:** April 2013                                              | 2020   | Medicare Utilization:              |                                  |           |
|        | **2022 Work RVU:**                                                            |        |                                    |                                  |           |
|        | **2022 NF PE RVU:**                                                           |        |                                    |                                  |           |
|        | **2022 Fac PE RVU:**                                                          |        |                                    |                                  |           |
|        | **RUC Recommendation:** Deleted from CPT                                      |        |                                    |                                  |           |
|        | **Result:** Referred to CPT, Published in CPT Asst:                          |        |                                    |                                  |           |
|        | **Referred to CPT Asst Published in CPT Asst:**                              |        |                                    |                                  |           |

| 31622  | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when        | 000    | Bronchial Aspiration of Tracheobronchial Tree | High Volume Growth2          | Yes       |
|        | performed; diagnostic, with cell washing, when performed (separate procedure) |        |                                    |                                  |           |
|        | **Most Recent RUC Meeting:** January 2015                                     |        |                                    |                                  |           |
|        | **Tab:** 05, **Specialty Developing Recommendation:** ACCP, ATS               |        |                                    |                                  |           |
|        | **First Identified:** April 2013                                              | 2020   | Medicare Utilization:              |                                  |           |
|        | **2022 Work RVU:** 2.53, **2022 NF PE RVU:** 4.60, **2022 Fac PE RVU:** 1.04 |        |                                    |                                  |           |
|        | **RUC Recommendation:** 2.78                                                  |        |                                    |                                  |           |
|        | **Result:** Referred to CPT, Published in CPT Asst:                          |        |                                    |                                  |           |
|        | **Referred to CPT Asst Published in CPT Asst:**                              |        |                                    |                                  |           |

| 31623  | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when        | 000    | Diagnostic Bronchoscopy            | High Volume Growth4           | Yes       |
|        | performed; with brushing or protected brushings                               |        |                                    |                                  |           |
|        | **Most Recent RUC Meeting:** October 2017                                     |        |                                    |                                  |           |
|        | **Tab:** 09, **Specialty Developing Recommendation:** ATS, CHEST              |        |                                    |                                  |           |
|        | **First Identified:** October 2016                                            | 2020   | Medicare Utilization:              |                                  |           |
|        | **2022 Work RVU:** 2.63, **2022 NF PE RVU:** 5.48, **2022 Fac PE RVU:** 1.02 |        |                                    |                                  |           |
|        | **RUC Recommendation:** 2.63                                                  |        |                                    |                                  |           |
|        | **Result:** Referred to CPT, Published in CPT Asst:                          |        |                                    |                                  |           |
|        | **Referred to CPT Asst Published in CPT Asst:**                              |        |                                    |                                  |           |
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| 31632   | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when      | ZZZ    | Endobronchial Ultrasound - EBUS | High Volume Growth 2 | Yes       |        |
|         | performed; with transbronchial lung biopsy(s), each additional lobe (list |        |                  |                   |           |        |
|         | separately in addition to code for primary procedure)                      |        |                  |                   |           |        |
| Most    | RUC Meeting: January 2015                                                  | 05     | First            | April 2013        | 2022 Work RVU: 1.03 |
| Recent  | RUC Meeting: January 2015                                                  |        | Identified:      |                   | 2022 NF PE RVU: 0.80 |
|         | Tab: 05                       | Specialty Developing Recommendation: ACCP, ATS |        | Medicare Utilization: 3,345 | 2022 Fac PE RVU: 0.32 |
| RUC     | Recommendation: ACCP, ATS                                                  | 1.03   | Referred to CPT  |                      |         |
|         | Referred to CPT Asst                                                      |        | Published in CPT Asst: |                   |         |
|         | Result: Maintain                                                           |        |                  |                   |           |        |

<p>| 31633   | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when      | ZZZ    | Endobronchial Ultrasound - EBUS | High Volume Growth 2 | Yes       |        |
|         | performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure) |        |                  |                   |           |        |
| Most    | RUC Meeting: January 2015                                                  | 05     | First            | April 2013        | 2022 Work RVU: 1.32 |
| Recent  | RUC Meeting: January 2015                                                  |        | Identified:      |                   | 2022 NF PE RVU: 0.95 |
|         | Tab: 05                       | Specialty Developing Recommendation: ACCP, ATS |        | Medicare Utilization: 965 | 2022 Fac PE RVU: 0.41 |
| RUC     | Recommendation: ACCP, ATS                                                  | 1.32   | Referred to CPT  |                      |         |
|         | Referred to CPT Asst                                                      |        | Published in CPT Asst: |                   |         |
|         | Result: Maintain                                                           |        |                  |                   |           |        |</p>
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<td>and/or hilar lymph node stations or structures</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>Endobronchial Ultrasound - EBUS</td>
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<td>31654</td>
<td>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])</td>
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<td>Bronchial Aspiration of Tracheobronchial Tree</td>
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<td>32201</td>
<td>Pneumonostomy; with percutaneous drainage of abscess or cyst</td>
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<td>Drainage of Abscess</td>
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#### Most Recent RUC Meeting: January 2015

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#### RUC Recommendation:

- 31653: 5.50
- 31654: 1.70
- 32201: Deleted from CPT

#### Result:

- Decrease

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Biopsy, lung or mediastinum, percutaneous needle</td>
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<td>Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed</td>
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<td>Pneumocentesis, puncture of lung for aspiration</td>
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Tuesday, February 1, 2022
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**Most Recent RUC Meeting**: September 2011

**Specialty Developing Recommendation**: ACCP, ACR, ATS, SIR, SCCM, STS

**First Identified**: September 2011

**2020 Medicare Utilization**: Thoracentesis with Tube Insertion

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

**Result**: Deleted from CPT

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<td>Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)</td>
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**Most Recent RUC Meeting**: September 2011

**Specialty Developing Recommendation**: ACCP, ACR, ATS, SIR, SCCM, STS

**First Identified**: April 2011

**2020 Medicare Utilization**: Thoracentesis with Tube Insertion

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

**Result**: Deleted from CPT

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<td>RAW Review</td>
<td>CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013</td>
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**Most Recent RUC Meeting**: January 2013

**Specialty Developing Recommendation**: ACCP, ATS, ACR, ACS, SIR, SCCM, STS

**First Identified**: November 2011

**2020 Medicare Utilization**: Thoracentesis with Tube Insertion

**Screen**: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

**Result**: Remove from screen
### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
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| 32663 | Thoracoscopy, surgical; with lobectomy (single lobe) | 090    | RAW review | CMS Fastest Growing | Yes |
|       | **Most Recent RUC Meeting:** January 2013 |        |       |        |           |
|       | **Tab:** 34 |        |       |        |           |
|       | **Specialty Developing Recommendation:** STS |        |       |        |           |
|       | **First Identified:** October 2008 |        |       |        |           |
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|       | **2022 Fac PE RVU:** 10.60 |        |       |        |           |
|       | **RUC Recommendation:** No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. |        |       |        |           |
|       | **Referred to CPT** |        |       |        |           |
|       | **Referred to CPT Asst** |        |       |        |           |
|       | **Result:** Remove from Screen |        |       |        |           |
|       | **Published in CPT Asst:** |        |       |        |           |

| 33010 | Pericardiocentesis; initial | 090    | Pericardiocentesis and Pericardial Drainage | Negative IWPUT | Yes |
|       | **Most Recent RUC Meeting:** January 2019 |        |       |        |           |
|       | **Tab:** 04 |        |       |        |           |
|       | **Specialty Developing Recommendation:** |        |       |        |           |
|       | **First Identified:** September 2018 |        |       |        |           |
|       | **2020 Medicare Utilization:** |        |       |        |           |
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|       | **2022 NF PE RVU:** |        |       |        |           |
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|       | **September 2018** |        |       |        |           |
|       | **Result:** Deleted from CPT |        |       |        |           |
|       | **Published in CPT Asst:** |        |       |        |           |

| 33011 | Pericardiocentesis; subsequent | 090    | Pericardiocentesis and Pericardial Drainage | Negative IWPUT | Yes |
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|       | **Published in CPT Asst:** |        |       |        |           |
## Status Report: CMS Requests and Relativity Assessment Issues

### 33015  Tube pericardiostomy

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**First Identified:** April 2017  
**2020 Medicare Utilization:**  
**Referred to CPT Asst Published in CPT Asst:**  
**Result:** Deleted from CPT

### 33016  Pericardiocentesis, including imaging guidance, when performed

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**Tab:** 04  
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**First Identified:** September 2018  
**2020 Medicare Utilization:**  
**Referred to CPT September 2018**  
**Result:** Increase

### 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

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**First Identified:** September 2018  
**2020 Medicare Utilization:**  
**Referred to CPT September 2018**  
**Result:** Increase
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<td>percutaneous, including fluoroscopy and/or ultrasound guidance,</td>
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<td>when performed; birth through 5 years of age or any age with</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 33207 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular

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### 33208 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular

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### 33212 Insertion of pacemaker pulse generator only; with existing single lead

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# Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 33284  Removal of an implantable, patient-activated cardiac event recorder

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### 33405  Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

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<td>Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)</td>
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<td>Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>33622</td>
<td>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)</td>
<td>090</td>
<td>New Technology Review</td>
<td>New Technology/New Services / CPT Assistant Analysis 2018</td>
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**Most Recent RUC Meeting:** January 2019  
**Tab:** 37  
**Specialty Developing Recommendation:** STS  
**First Identified:** January 2015  
**2020 Medicare Utilization:**  
- 2022 Work RVU: 64.00  
- 2022 NF PE RVU: NA  
- 2022 Fac PE RVU: 21.27  

**RUC Recommendation:** CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified.

- Referred to CPT:  
- Referred to CPT Asst: Yes  
- Published in CPT Asst: July 2016

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<td>33741</td>
<td>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)</td>
<td>000</td>
<td>Atrial Septostomy</td>
<td>CMS Request - Final Rule for 2019</td>
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**Most Recent RUC Meeting:** January 2020  
**Tab:** 13  
**Specialty Developing Recommendation:**  
**First Identified:** September 2019  
**2020 Medicare Utilization:**  
- 2022 Work RVU: 14.00  
- 2022 NF PE RVU: NA  
- 2022 Fac PE RVU: 4.83  

**RUC Recommendation:** 14.00

- Referred to CPT: September 2019  
- Referred to CPT Asst: Yes  
- Published in CPT Asst:  

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<tr>
<td>33745</td>
<td>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</td>
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<td>Atrial Septostomy</td>
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**Most Recent RUC Meeting:** January 2020  
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**First Identified:** September 2019  
**2020 Medicare Utilization:**  
- 2022 Work RVU: 20.00  
- 2022 NF PE RVU: NA  
- 2022 Fac PE RVU: 6.90  

**RUC Recommendation:** 20.00

- Referred to CPT: September 2019  
- Referred to CPT Asst: Yes  
- Published in CPT Asst:  

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## 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 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)

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Referred to CPT: September 2019

Result: Maintain

### 33863  Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, bentall)

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Referred to CPT: February 2008

Result: Remove from Screen

### 33945  Heart transplant, with or without recipient cardiectomy

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Referred to CPT: February 2014

Result: Maintain
### Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous

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<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial</td>
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<tr>
<td>33949</td>
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*Result: Maintain*
# Status Report: CMS Requests and Relativity Assessment Issues

## Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS)

**Issue:** ECMO-ECLS

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**Screen:** CMS Request - Final Rule for 2014

- **2022 Work RVU:** 8.15
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.35

**Referred to CPT Published in CPT Asst:**
- February 2014
- Result: Maintain

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## Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS)

**Issue:** ECMO-ECLS

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**Screen:** CMS Request - Final Rule for 2014

- **2022 Work RVU:** 8.15
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.57

**Referred to CPT Published in CPT Asst:**
- February 2014
- Result: Maintain

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## Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS)

**Issue:** ECMO-ECLS

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**Screen:** CMS Request - Final Rule for 2014

- **2022 Work RVU:** 9.11
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 2.61

**Referred to CPT Published in CPT Asst:**
- February 2014
- Result: Maintain
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<td>Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
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<td>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)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day</td>
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<td>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)</td>
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<td>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)</td>
<td>9.00</td>
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### 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

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- **RUC Recommendation:** 9.50  
- **Result:** Maintain

- **Referred to CPT:** February 2014  
- **Published in CPT Asst:**

### 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

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- **RUC Recommendation:** 3.51  
- **Result:** Maintain

- **Referred to CPT:** February 2014  
- **Published in CPT Asst:**

### 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

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- **RUC Recommendation:** 4.50  
- **Result:** Maintain

- **Referred to CPT:** February 2014  
- **Published in CPT Asst:**

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**Tuesday, February 1, 2022**
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<td>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)</td>
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<td>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)</td>
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<td>34706</td>
<td>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)</td>
<td>090</td>
<td>Endovascular Repair Procedures (EVAR)</td>
<td>Codes Reported Together 75% or More-Part3</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

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<th>Endovascular Repair Procedures (EVAR)</th>
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<tr>
<td>34707</td>
<td>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)</td>
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<td>January 2017</td>
<td>First Identified: January 2017</td>
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<tr>
<td>34708</td>
<td>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)</td>
<td>2022 Work RVU: 36.50</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>34709</td>
<td>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)</td>
<td>ZZZ</td>
<td>Endovascular Repair Procedures (EVAR)</td>
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<td>34710</td>
<td>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</td>
<td>090</td>
<td>Endovascular Repair Procedures (EVAR)</td>
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**Most Recent RUC Meeting**: January 2017  
**Tab**: 10  
**Specialty Developing Recommendation**: SVS, SIR, STS, AATS, ACS  
**First Identified**: January 2017  
**2020 Medicare Utilization**: 2,552  
**2022 Work RVU**: 6.50  
**2022 NF PE RVU**: NA  
**2022 Fac PE RVU**: 1.38  
**RUC Recommendation**: 6.50  
**Referred to CPT Asst**: No  
**Published in CPT Asst**: No  
**Result**: Decrease

**Most Recent RUC Meeting**: January 2017  
**Tab**: 10  
**Specialty Developing Recommendation**: SVS, SIR, STS, AATS, ACS  
**First Identified**: January 2017  
**2020 Medicare Utilization**: 1,049  
**2022 Work RVU**: 15.00  
**2022 NF PE RVU**: NA  
**2022 Fac PE RVU**: 4.70  
**RUC Recommendation**: 15.00  
**Referred to CPT Asst**: No  
**Published in CPT Asst**: No  
**Result**: Decrease

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**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)**

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).
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<tr>
<td>34711</td>
<td>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)</td>
<td>ZZZ</td>
<td>Endovascular Repair Procedures (EVAR)</td>
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<td>34712</td>
<td>Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation</td>
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<td>34713</td>
<td>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)</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>34714</td>
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<td>34715</td>
<td>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)</td>
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<td>34802 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)</td>
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<td>34803 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)</td>
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<td>34806</td>
<td>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)</td>
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<td>34812</td>
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Note: The document contains technical and medical information related to endovascular repair procedures, including codes, recommendations, and utilization data.
### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** January 2017

**Tab:** 10  **Specialty Developing Recommendation:** SVS, SIR, STS, AATS  **First Identified:** January 2017

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

**Deleted from CPT**

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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

#### 34900
**Endovascular repair of iliac artery (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis**

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

#### 35301
**Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision**

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**First Identified:** September 2011  
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**RUC Recommendation:** 21.16  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**  
**Result:** Increase

#### 35450
**Transluminal balloon angioplasty, open; renal or other visceral artery**

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- **RUC Meeting Dates:**
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  - April 2010
  - January 2016
- **Specialty Developing Recommendations:**
  - ACR, SIR, SVS
  - ACC, ACR, SIR, SVS
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- **Referred to CPT:**
  - February 2010
  - October 2015
- **Screen:**
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Tuesday, February 1, 2022
### Transluminal balloon angioplasty, percutaneous; venous

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**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**RUC Recommendation:** Deleted from CPT  
**Result:** Deleted from CPT  
**Referred to CPT** October 2015  
**Referred to CPT Asst**  
**Published in CPT Asst**

### Endovascular Revascularization

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<tbody>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 07  
**Specialty Developing Recommendation:** SIR, ACR, SVS  
**First Identified:** April 2008  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**RUC Recommendation:** Deleted from CPT  
**Result:** Deleted from CPT  
**Referred to CPT** February 2010  
**Referred to CPT Asst**  
**Published in CPT Asst**

### Endovascular Revascularization

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**Most Recent RUC Meeting:** April 2010  
**Tab:** 07  
**Specialty Developing Recommendation:** SIR, ACR, SVS  
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Tuesday, February 1, 2022
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### Status Report: CMS Requests and Relativity Assessment Issues

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| 35761  | Exploration (not followed by surgical repair), with or without lysis of artery; other vessels |        | Exploration of Artery  | Negative IWPUT       | Yes       |
|        |                                                                             |        |                        |                      |           |
|        |                                                                             |        | First Identified: April 2017 | 2020 Medicare Utilization: |           |
|        |                                                                             |        | Referred to CPT September 2018 | Result: Deleted from CPT |           |
|        |                                                                             |        | Published in CPT Asst:   |                      |           |
|        | Most Recent RUC Meeting: January 2019                                       |        | Tab: 06                | Specialty Developing |          |
|        |                                                                             |        |                         | Recommendation:      |           |
|        |                                                                             |        |                         | ACS, SVS             |           |
|        |                                                                             |        |                         | First Identified:    |           |
|        |                                                                             |        |                         | October 2009          |           |
|        |                                                                             |        |                         | Referred to CPT:     |           |
|        |                                                                             |        |                         | September 2018        |           |
|        |                                                                             |        |                         | Published in CPT Asst:|           |
|        | RUC Recommendation: Deleted from CPT                                         |        |                         |                      |           |

| 36000  | Introduction of needle or intracatheter, vein                               | Harvard Valued - Utilization over 100,000 | Introduction of Needle or Intracatheter | Yes       |
|        |                                                                             |        |                        |                      |           |
|        |                                                                             |        | First Identified: October 2009 | 2020 Medicare Utilization: |           |
|        |                                                                             |        | Referred to CPT         | Result: Maintain     |           |
|        |                                                                             |        | Published in CPT Asst:   |                      |           |
|        | Most Recent RUC Meeting: April 2010                                         |        | Tab: 45                | Specialty Developing |          |
|        |                                                                             |        |                         | Recommendation:      |           |
|        |                                                                             |        |                         | ACC, AUR, AAP, AAFP, ACRh |         |
|        |                                                                             |        |                         | First Identified:    |           |
|        |                                                                             |        |                         | October 2009          |           |
|        |                                                                             |        |                         | Referred to CPT:     |           |
|        |                                                                             |        |                         | October 2013          |           |
|        | RUC Recommendation: CMS consider a bundled status for this code             |        |                         |                      |           |

| 36010  | Introduction of catheter, superior or inferior vena cava                    | Codes Reported Together 75% or More-Part1 | Introduction of Catheter | Yes       |
|        |                                                                             |        |                        |                      |           |
|        |                                                                             |        | First Identified: February 2010 | 2020 Medicare Utilization: |           |
|        |                                                                             |        | Referred to CPT         | Result: Remove from screen |           |
|        |                                                                             |        | Published in CPT Asst:   |                      |           |
|        | Most Recent RUC Meeting: October 2013                                       |        | Tab: 18                | Specialty Developing |          |
|        |                                                                             |        |                         | Recommendation:      |           |
|        |                                                                             |        |                         | ACR, SIR, SVS        |           |
|        |                                                                             |        |                         | First Identified:    |           |
|        |                                                                             |        |                         | February 2010         |           |
|        |                                                                             |        |                         | Referred to CPT:     |           |
|        |                                                                             |        |                         | February 2011         |           |
|        | RUC Recommendation: Remove from re-review.                                   |        |                         |                      |           |

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Tuesday, February 1, 2022
**Status Report: CMS Requests and Relativity Assessment Issues**

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## Status Report: CMS Requests and Relativity Assessment Issues

### 36217

**Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

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**Most Recent RUC Meeting:** April 2016  
**Tab:** 23  
**Specialty Developing Recommendation:** ACR, SIR, SVS  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 3,625

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**RUC Recommendation:** 6.29  
**Result:** Maintain

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### 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)

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**First Identified:** July 2015  
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**RUC Recommendation:** 1.01  
**Result:** Maintain

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### 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**

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**Most Recent RUC Meeting:** April 2012  
**Tab:** 14  
**Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 1,758

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**RUC Recommendation:** 4.51  
**Result:** Decrease

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>36223</td>
<td>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</td>
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<td>36224</td>
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#### Most Recent RUC Meeting
- **36222** April 2012
- **36223** October 2020
- **36224** October 2020

#### Tab
- **36222**: 14
- **36223**: 24
- **36224**: 24

#### Specialty Developing Recommendation
- **AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS**

#### First Identified
- **February 2010**

#### Global
- **000**

#### Issue
- Cervicocerebral Angiography

#### Screen
- Codes Reported Together 75% or More-Part1

#### Complete?
- Yes

#### 2022 Work RVU
- **5.28**

#### 2022 NF PE RVU
- **30.52**

#### 2022 Fac PE RVU
- **1.79**

#### Medicare Utilization
- **5,920**

#### Result
- Decrease

#### Referred to CPT
- February 2012

#### Referred to CPT Asst
- Published in CPT Asst
### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Cervicocerebral Angiography</td>
<td>Codes Reported Together 75% or More-Part1</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Renal Angiography</th>
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**Result:** Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated</td>
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<td>Endovenous Ablation</td>
<td>High Volume Growth2</td>
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## Therapeutic Apheresis

### 36511

- **Issue:** Therapeutic Apheresis
- **Screen:** CMS Request - Final Rule for 2016
- **Complete?** Yes

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### 36512

- **Issue:** Therapeutic Apheresis
- **Screen:** CMS Request - Final Rule for 2016
- **Complete?** Yes

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### 36513

- **Issue:** Therapeutic Apheresis
- **Screen:** CMS Request - Final Rule for 2016
- **Complete?** Yes

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### 36514

- **Issue:** Therapeutic Apheresis
- **Screen:** CMS Request - Final Rule for 2016
- **Complete?** Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

### 36515 Therapeutic Apheresis; with extracorporeal immunoadsorption and plasma reinfusion

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**Tab:** 12  
**Specialty Developing Recommendation:** CAP, RPA  
**First Identified:** January 2017

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**RUC Recommendation:** Deleted from CPT  
**Referred to CPT Asst Published in CPT Asst:** May 2018

**Result:** Published in CPT Asst

### 36516 Therapeutic Apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion

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**Most Recent RUC Meeting:** January 2017  
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**First Identified:** October 2008

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**RUC Recommendation:** 1.56. Refer to CPT Assistant  
**Referred to CPT Asst Published in CPT Asst:** Sep 2009

**Result:** Increase

### 36522 Photopheresis, extracorporeal

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**RUC Recommendation:** 1.75. Refer to CPT Assistant  
**Referred to CPT Asst Published in CPT Asst:** May 2018

**Result:** Increase
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<td><strong>36555</strong> Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age</td>
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<thead>
<tr>
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<tr>
<th><strong>36568</strong> Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 36569
- **Global:** 000  
  **Issue:** PICC Line Procedures  
  **Screen:** CMS High Expenditure Procedural Codes  
  **Complete?** Yes

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- **RUC Recommendation:** 1.90. Review at RAW in October 2021.
- **Result:** Decrease
- **Published in CPT Asst:**

### 36572
- **Global:** 000  
  **Issue:** PICC Line Procedures  
  **Screen:** CMS High Expenditure Procedural Codes  
  **Complete?** Yes

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- **RUC Recommendation:** 2.00
- **Result:** Decrease
- **Published in CPT Asst:**

### 36573
- **Global:** 000  
  **Issue:** PICC Line Procedures  
  **Screen:** CMS High Expenditure Procedural Codes  
  **Complete?** Yes

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- **RUC Recommendation:** 1.90
- **Result:** Decrease
- **Published in CPT Asst:**
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<td>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</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>36822</th>
<th>Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)</th>
<th>Global:</th>
<th>Issue: ECMO-ECLS</th>
<th>Screen: CMS Request - Final Rule for 2014</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> April 2014</td>
<td><strong>Tab:</strong> 11 <strong>Specialty Developing Recommendation:</strong> STS, AAP, ACC, SCAI</td>
<td><strong>First Identified:</strong> February 2011</td>
<td><strong>2020 Medicare Utilization:</strong></td>
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<td><strong>Referred to CPT:</strong> February 2014</td>
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<table>
<thead>
<tr>
<th>36825</th>
<th>Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft</th>
<th>Global: 090</th>
<th>Issue: Arteriovenous Anastomosis</th>
<th>Screen: Site of Service Anomaly / CMS Request - Final Rule for 2013</th>
<th>Complete? Yes</th>
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</thead>
<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> October 2013</td>
<td><strong>Tab:</strong> 10 <strong>Specialty Developing Recommendation:</strong> ACS, SVS</td>
<td><strong>First Identified:</strong> September 2007</td>
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<thead>
<tr>
<th>36830</th>
<th>Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)</th>
<th>Global: 090</th>
<th>Issue: Arteriovenous Anastomosis</th>
<th>Screen: CMS Request - Final Rule for 2013</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> October 2013</td>
<td><strong>Tab:</strong> 10 <strong>Specialty Developing Recommendation:</strong> ACS, SVS</td>
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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

### 36834  Deleted from CPT

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue: Aneurysm Repair</th>
<th>Screen: Site of Service Anomaly</th>
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<td>Published in CPT Asst:</td>
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### 36870  Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue: Dialysis Circuit -1</th>
<th>Screen: Site of Service Anomaly</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting:</td>
<td>January 2016</td>
<td>First Identified:</td>
<td>September 2007</td>
<td>2020 Medicare Utilization:</td>
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<tr>
<td>Tab: 14 Specialty Developing Recommendation:</td>
<td>ACR, SIR, SVS</td>
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<tr>
<td>RUC Recommendation:</td>
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<td>Referred to CPT</td>
<td>October 2015</td>
<td>Result: Deleted from CPT</td>
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<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
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### 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;

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue: Dialysis Circuit -1</th>
<th>Screen: Codes Reported Together 75% or More-Part3</th>
<th>Complete?</th>
<th>Yes</th>
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<tr>
<td>Most Recent RUC Meeting:</td>
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<td>First Identified:</td>
<td>October 2015</td>
<td>2020 Medicare Utilization:</td>
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<tr>
<td>Tab: 14 Specialty Developing Recommendation:</td>
<td>ACR, RPA, SIR, SVS</td>
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<tr>
<td>RUC Recommendation:</td>
<td>3.36</td>
<td>Referred to CPT</td>
<td>October 2015</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>36902</td>
<td>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</td>
<td>000</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** January 2016  
**RUC Recommendation:** 4.83  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 180,136  
**Result:** Decrease

- **2022 Work RVU:** 4.83  
- **2022 NF PE RVU:** 31.90  
- **2022 Fac PE RVU:** 1.47  
- **Referred to CPT** October 2015  
- **Referred to CPT Asst**  
- **Published in CPT Asst:**

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<tbody>
<tr>
<td>36903</td>
<td>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</td>
<td>000</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
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**Most Recent RUC Meeting:** January 2016  
**RUC Recommendation:** 6.39  
**First Identified:** October 2015  
**2020 Medicare Utilization:** 19,278  
**Result:** Decrease

- **2022 Work RVU:** 6.39  
- **2022 NF PE RVU:** 127.30  
- **2022 Fac PE RVU:** 1.82  
- **Referred to CPT** October 2015  
- **Referred to CPT Asst**  
- **Published in CPT Asst:**

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Tuesday, February 1, 2022
# Status Report: CMS Requests and Relativity Assessment Issues

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<th>Issue</th>
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<tr>
<td>36904</td>
<td>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);</td>
<td>000</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
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<td><strong>Most Recent RUC Meeting:</strong> January 2016</td>
<td><strong>Tab:</strong> 14</td>
<td><strong>Specialty Developing Recommendation:</strong> ACR, RPA, SIR, SVS</td>
<td><strong>First Identified:</strong> October 2015</td>
<td><strong>2020 Medicare Utilization:</strong> 3,960</td>
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<td><strong>RUC Recommendation:</strong> 7.50</td>
<td><strong>Referred to CPT:</strong> October 2015</td>
<td><strong>Referral to CPT Asst:</strong> No Published in CPT Asst:</td>
<td><strong>Result:</strong> Decrease</td>
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<tr>
<td>36905</td>
<td>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</td>
<td>000</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
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<td><strong>Most Recent RUC Meeting:</strong> January 2016</td>
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<td><strong>Specialty Developing Recommendation:</strong> ACR, RPA, SIR, SVS</td>
<td><strong>First Identified:</strong> October 2015</td>
<td><strong>2020 Medicare Utilization:</strong> 38,039</td>
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<td><strong>Referred to CPT:</strong> October 2015</td>
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<td><strong>Result:</strong> Decrease</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tr>
<td>36906</td>
<td>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 intra procedural pharmacological thrombolytic injection(s); with trans catheter 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</td>
<td>000</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
<td>Yes</td>
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<tr>
<td>36907</td>
<td>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)</td>
<td>ZZZ</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
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<tr>
<td>36908</td>
<td>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)</td>
<td>ZZZ</td>
<td>Dialysis Circuit -1</td>
<td>Codes Reported Together 75% or More-Part3</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** January 2016

**Tab:** 14  
**Specialty Developing Recommendation:** ACR, RPA, SIR, SVS

**First Identified:** October 2015

**2020 Medicare Utilization:**

- **2022 Work RVU:** 10.42
- **2022 NF PE RVU:** 158.47
- **2022 Fac PE RVU:** 3.01

**Result:** Decrease

**Referral to CPT:** October 2015  
**Referred to CPT Asst:**

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**Codes Reported Together 75% or More-Part3**

**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 intra procedural pharmacological thrombolytic injection(s); with trans catheter 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**

- Codes: 10.42
- Referred to CPT: October 2015
- Published in CPT Asst: No

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**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)**

- Codes: 3.00
- Referred to CPT: October 2015
- Published in CPT Asst: No

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**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)**

- Codes: 4.25
- Referred to CPT: October 2015
- Published in CPT Asst: No
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Tab</th>
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<th>Medicare Utilization</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
<th>Result</th>
<th>Complete?</th>
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<tbody>
<tr>
<td><strong>36909</strong> 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)</td>
<td>ZZZ</td>
<td>14</td>
<td>ACR, RPA, SIR, SVS</td>
<td>October 2015</td>
<td>4,891</td>
<td>4.12</td>
<td>55.62</td>
<td>1.11</td>
<td>Decrease</td>
<td>Yes</td>
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<td><strong>37183</strong> 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)</td>
<td>000</td>
<td>21</td>
<td>ACR, SIR</td>
<td>NA</td>
<td>850</td>
<td>7.74</td>
<td>174.69</td>
<td>2.35</td>
<td>PE Only</td>
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<td><strong>37191</strong> Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intra procedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed</td>
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<td>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</td>
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<td>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)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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, intraprocuderal roadmapping, and imaging guidance necessary to complete the procedure</td>
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<th>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</th>
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Tuesday, February 1, 2022  |  |  |  |  |  |  |  |
### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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| 37233 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, | ZZZ    | Endovascular Revascularization | High Volume Growth1                         | No        |
|       | unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) |        |                           |                                             |           |
|       | **Most Recent RUC Meeting:** January 2019                                    |        |                           |                                             |           |
|       | **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC              |        |                           |                                             |           |
|       | **First Identified:** February 2010                                           |        |                           |                                             |           |
|       | **2020 Medicare Utilization:** 8,651                                          |        |                           |                                             |           |
|       | **2022 Work RVU:** 6.50                                                       |        |                           |                                             |           |
|       | **2022 NF PE RVU:** 24.00                                                     |        |                           |                                             |           |
|       | **2022 Fac PE RVU:** 1.62                                                     |        |                           |                                             |           |
|       | **RUC Recommendation:** Refer to CPT. 6.50                                   |        |                           |                                             |           |
|       | **Referred to CPT**                                                          |        |                           |                                             |           |
|       | **February 2022**                                                            |        |                           |                                             |           |
|       | **Referred to CPT Asst**                                                      |        |                           |                                             |           |
|       | **Published in CPT Asst:**                                                    |        |                           |                                             |           |
|       | **Result:** Decrease                                                         |        |                           |                                             |           |

| 37234 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, | ZZZ    | Endovascular Revascularization | High Volume Growth1                         | No        |
|       | 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) |        |                           |                                             |           |
|       | **Most Recent RUC Meeting:** January 2019                                    |        |                           |                                             |           |
|       | **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC              |        |                           |                                             |           |
|       | **First Identified:** February 2010                                           |        |                           |                                             |           |
|       | **2020 Medicare Utilization:** 402                                            |        |                           |                                             |           |
|       | **2022 Work RVU:** 5.50                                                       |        |                           |                                             |           |
|       | **2022 NF PE RVU:** 106.58                                                    |        |                           |                                             |           |
|       | **2022 Fac PE RVU:** 1.56                                                     |        |                           |                                             |           |
|       | **RUC Recommendation:** Refer to CPT. 5.50                                   |        |                           |                                             |           |
|       | **Referred to CPT**                                                          |        |                           |                                             |           |
|       | **February 2022**                                                            |        |                           |                                             |           |
|       | **Referred to CPT Asst**                                                      |        |                           |                                             |           |
|       | **Published in CPT Asst:**                                                    |        |                           |                                             |           |
|       | **Result:** Decrease                                                         |        |                           |                                             |           |
### Status Report: CMS Requests and Relativity Assessment Issues

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| 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 | 000 | Transcatheter Placement of Intravascular Stent | Codes Reported Together 75% or More-Part1 | Yes |
| Most Recent RUC Meeting: | April 2013 | Specialty Developing Recommendation: | SVS, ACS, SIR, ACR, ACC | First Identified: | February 2013 |
| 2020 Medicare Utilization: | 11,118 | 2022 Work RVU: | 8.75 | 2022 NF PE RVU: | 75.20 |
| 2022 Fac PE RVU: | 2.28 | Referred to CPT: | February 2013 | Result: | Decrease |
| Referred to CPT Asst: | Published in CPT Asst: |

| 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) | ZZZ | Transcatheter Placement of Intravascular Stent | Codes Reported Together 75% or More-Part1 | Yes |
| Most Recent RUC Meeting: | April 2013 | Specialty Developing Recommendation: | SVS, ACS, SIR, ACR, ACC | First Identified: | February 2013 |
| 2020 Medicare Utilization: | 1,341 | 2022 Work RVU: | 4.25 | 2022 NF PE RVU: | 34.98 |
| 2022 Fac PE RVU: | 0.97 | Referred to CPT: | February 2013 | Result: | Decrease |
| Referred to CPT Asst: | Published in CPT Asst: |
### Transcatheter Placement of Intravascular Stent

**Description:** 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

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### Transcatheter Placement of Intravascular Stent

**Description:** 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)

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### Vascular Embolization or Occlusion

**Description:** 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)

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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 (e.g., 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  **2020 Medicare Utilization:** 8,018

**2022 Work RVU:** 9.80  **2022 NF PE RVU:** 212.05  **2022 Fac PE RVU:** 2.55

Referred to CPT  Referred to CPT Asst  Published in CPT Asst:  Result: Decrease

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  **2020 Medicare Utilization:** 13,506

**2022 Work RVU:** 11.74  **2022 NF PE RVU:** 256.53  **2022 Fac PE RVU:** 3.33

Referred to CPT  Referred to CPT Asst  Published in CPT Asst:  Result: Decrease

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  **2020 Medicare Utilization:** 13,195

**2022 Work RVU:** 13.75  **2022 NF PE RVU:** 190.53  **2022 Fac PE RVU:** 4.05

Referred to CPT  Referred to CPT Asst  Published in CPT Asst:  Result: Decrease
# Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>37249</td>
<td>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)</td>
<td>ZZZ</td>
<td>Open and Percutaneous Transluminal Angioplasty</td>
<td>Codes Reported Together 75% or More-Part3</td>
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**RUC Recommendation:** 2.97

- **Most Recent RUC Meeting:** January 2016
- **Tab:** 15
- **Specialty Developing Recommendation:** ACR, SIR, SVS

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<td><strong>2022 Fac PE RVU:</strong> 0.76</td>
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**Result:**
- Referred to CPT: October 2015
- Referred to CPT Asst Published in CPT Asst:

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<tr>
<td>37250</td>
<td>Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)</td>
<td></td>
<td>Intravascular Ultrasound</td>
<td>Final Rule for 2015</td>
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**RUC Recommendation:** Deleted from CPT

- **Most Recent RUC Meeting:** January 2015
- **Tab:** 07
- **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS

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<td><strong>2022 Fac PE RVU:</strong></td>
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**Result:**
- Referred to CPT: October 2014
- Referred to CPT Asst Published in CPT Asst:

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<tr>
<td>37251</td>
<td>Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)</td>
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<td>Intravascular Ultrasound</td>
<td>Final Rule for 2015</td>
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**RUC Recommendation:** Deleted from CPT

- **Most Recent RUC Meeting:** January 2015
- **Tab:** 07
- **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS

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<td><strong>2022 Work RVU:</strong></td>
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<td><strong>2022 NF PE RVU:</strong></td>
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<td><strong>2022 Fac PE RVU:</strong></td>
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**Result:**
- Referred to CPT: October 2014
- Referred to CPT Asst Published in CPT Asst:
Status Report: CMS Requests and Relativity Assessment Issues

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)


Most Recent RUC Meeting: October 2018  Tab: 14  Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014  2020 Medicare Utilization: 68,320

2022 Work RVU: 1.80  2022 NF PE RVU: 27.51  2022 Fac PE RVU: 0.45

RUC Recommendation: 1.80  Referred to CPT Asst Published in CPT Asst: 

Result: Decrease

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)


Most Recent RUC Meeting: October 2018  Tab: 14  Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014  2020 Medicare Utilization: 105,426

2022 Work RVU: 1.44  2022 NF PE RVU: 3.38  2022 Fac PE RVU: 0.36

RUC Recommendation: 1.44  Referred to CPT Asst Published in CPT Asst: 

Result: Decrease

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  2020 Medicare Utilization: 11,518

2022 Work RVU: 3.05  2022 NF PE RVU: 5.74  2022 Fac PE RVU: 2.36

RUC Recommendation: Reduce 99238 to 0.5  Referred to CPT Asst Published in CPT Asst: 

Result: PE Only
### Status Report: CMS Requests and Relativity Assessment Issues

#### 37619  Ligation of inferior vena cava

- **Global:** 090
- **Issue:** Ligation of Inferior Vena Cava
- **Screen:** Codes Reported Together 75% or More-Part1
- **Complete?** Yes

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<td>February 2011</td>
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- **2022 Work RVU:** 30.00
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 13.84

---

#### 37620  Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)

- **Global:** 090
- **Issue:** Major Vein Revision
- **Screen:** Codes Reported Together 75% or More-Part1
- **Complete?** Yes

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<tr>
<th>Most Recent RUC Meeting: April 2010</th>
<th>Tab: 45</th>
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<td>February 2011</td>
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- **2022 Work RVU:**
- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**

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#### 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

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<td>February 2009</td>
<td>Referred to CPT</td>
<td>Published in CPT Asst:</td>
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- **2022 Work RVU:** 10.78
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 3.47

---

**Note:**
- Ligation of Inferior Vena Cava
- Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)
- Ligation of perforator veins, subfascial, radical (linton type), including skin graft, when performed, open,1 leg

**Source:**
- Medicare Utilization:
  - Increase
- Codes Reported Together 75% or More-Part1

**Payment:**
- Work RVU: 30.00
- Fac PE RVU: 13.84
- NF PE RVU: NA

**Referred to CPT:**
- February 2011
- February 2011
- February 2009

**Published in CPT Asst:**
- Yes
- Yes
- Yes
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg</td>
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<td>Perforator Vein Ligation</td>
<td>Site of Service Anomaly</td>
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<td><strong>Most Recent RUC Meeting:</strong> April 2009 <strong>Tab:</strong> 10 <strong>Specialty Developing Recommendation:</strong> SVS, ACS</td>
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<td><strong>RUC Recommendation:</strong> 9.00 <strong>First Identified:</strong> April 2009 <strong>Referred to CPT</strong></td>
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<td>2022 NF PE RVU: NA</td>
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<td><strong>Referred to CPT Asst Published in CPT Asst:</strong></td>
<td>2022 Fac PE RVU: 4.46</td>
<td>Result: Increase</td>
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| 37765 | Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions        | 010    | Stab Phlebectomy of Varicose Veins | High Volume Growth1 / CMS Fastest Growing | Yes       |
|       | **Most Recent RUC Meeting:** April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS | 2020   | Medicare Utilization: 9,983      | 2022 Work RVU: 4.80  |
|       | **First Identified:** February 2008 **Referred to CPT** | NA     | 2022 NF PE RVU: 7.04             |           |
|       | **Referred to CPT Asst Published in CPT Asst:** | 2022 Fac PE RVU: 2.12 | Result: Decrease | |

| 37766 | Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions      | 010    | Stab Phlebectomy of Varicose Veins | High Volume Growth1 / CMS Fastest Growing | Yes       |
|       | **Most Recent RUC Meeting:** April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS | 2020   | Medicare Utilization: 8,158      | 2022 Work RVU: 6.00  |
|       | **First Identified:** February 2008 **Referred to CPT** | NA     | 2022 NF PE RVU: 7.69             |           |
|       | **Referred to CPT Asst Published in CPT Asst:** | 2022 Fac PE RVU: 2.44 | Result: Decrease | |

| 37785 | Ligation, division, and/or excision of varicose vein cluster(s), 1 leg       | 090    | Ligation                        | Site of Service Anomaly | Yes       |
|       | **Most Recent RUC Meeting:** September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS | 2020   | Medicare Utilization: 707       | 2022 Work RVU: 3.93  |
|       | **First Identified:** September 2007 **Referred to CPT** | NA     | 2022 NF PE RVU: 5.77             |           |
|       | **Referred to CPT Asst Published in CPT Asst:** | 2022 Fac PE RVU: 2.69 | Result: PE Only | |

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>38220</td>
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<td>Diagnostic Bone Marrow Aspiration and Biopsy</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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<td>ASCO, ASH, CAP ASBMT</td>
<td>February 2016</td>
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<td>February 2016</td>
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<td>Diagnostic Bone Marrow Aspiration and Biopsy</td>
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<td>February 2016</td>
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<td>Diagnostic Bone Marrow; aspiration(s) and biopsy(ies)</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
<td>April 2016</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 38505  Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)

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<td>Needle Biopsy of Lymph Nodes</td>
<td>Harvard Valued - Utilization over 30,000-Part4</td>
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**Most Recent RUC Meeting:** October 2020  
**Tab:** 15  
**Specialty Developing Recommendation:** ACR, SIR  
**First Identified:** October 2019  
**Medicare Utilization:** 32,769

**RUC Recommendation:** 1.59  
**Referred to CPT**  
**Published in CPT Asst:**

**2022 Work RVU:** 1.59  
**2022 NF PE RVU:** 3.60  
**2022 Fac PE RVU:** 0.77

#### 38542  Dissection, deep jugular node(s)

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<td>090</td>
<td>Jugular Node Dissection</td>
<td>Site of Service Anomaly</td>
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**Most Recent RUC Meeting:** April 2008  
**Tab:** 40  
**Specialty Developing Recommendation:** ACS, AAO-HNS  
**First Identified:** September 2007  
**Medicare Utilization:** 503

**RUC Recommendation:** 7.85  
**Referred to CPT**  
**Published in CPT Asst:**

**2022 Work RVU:** 7.95  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.19

#### 38570  Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple

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<td>Laparoscopy Lymphadenectomy</td>
<td>010-Day Global Post-Operative Visits</td>
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**Most Recent RUC Meeting:** September 2014  
**Tab:** 12  
**Specialty Developing Recommendation:** AUA  
**First Identified:** January 2014  
**Medicare Utilization:** 5,794

**RUC Recommendation:** 9.34  
**Referred to CPT**  
**Published in CPT Asst:**

**2022 Work RVU:** 8.49  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 5.28

**Result:** Increase
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Laparoscopy</td>
<td>CMS Fastest Growing / 010-Day Global Post-Operative Visits</td>
<td>Yes</td>
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<tr>
<td>Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple</td>
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Tuesday, February 1, 2022

Page 249 of 836
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<td>Repair lip, full thickness; vermilion only</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

**40800 Drainage of abscess, cyst, hematoma, vestibule of mouth; simple**

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 52  
**Specialty Developing Recommendation:** Maintain

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**RUC Recommendation:** Maintain

**Referred to CPT**

**Published in CPT Asst:**

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**40801 Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated**

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<td>Ostectomy</td>
<td>Site of Service Anomaly (99238-Only) / 010-Day Global Post-Operative Visits2</td>
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**Most Recent RUC Meeting:** January 2020  
**Tab:** 37  
**Specialty Developing Recommendation:** APMA, AAOS

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**RUC Recommendation:** Maintain. Reduced 99238 to 0.5

**Referred to CPT**

**Published in CPT Asst:**

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**40808 Biopsy, vestibule of mouth**

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<td>Biopsy of Mouth Lesion</td>
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**Most Recent RUC Meeting:** April 2018  
**Tab:** 13  
**Specialty Developing Recommendation:** AAOHNS, AAOMS

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**RUC Recommendation:** 1.05

**Referred to CPT**

**Published in CPT Asst:**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>40820</td>
<td>40820</td>
<td>Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)</td>
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<td>Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session</td>
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Tuesday, February 1, 2022
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<td><strong>42415</strong> Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve</td>
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<td><strong>2020 Medicare Utilization:</strong></td>
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<tr>
<td><strong>42420</strong> Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve</td>
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<td><strong>Global:</strong> 090  <strong>Issue:</strong> Excise Parotid Gland/Lesion  <strong>Screen:</strong> Site of Service Anomaly  <strong>Complete?</strong> Yes</td>
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<td><strong>42440</strong> Excision of submandibular (submaxillary) gland</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

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- **Tab:** 10
- **Referred to CPT:**
- **Published in CPT Asst:**

| 43193  | Esophagoscopy, rigid, transoral; with biopsy, single or multiple             | 000    | Esophagoscopy | MPC List | Yes       | October 2012           | AAO-HNS, ASGE, SAGES          | September 2011 | 196             | 2.79         | NA           | 1.78         | Increase |

- **Tab:** 10
- **Referred to CPT:**
- **Published in CPT Asst:**

| 43194  | Esophagoscopy, rigid, transoral; with removal of foreign body(s)            | 000    | Esophagoscopy | MPC List | Yes       | October 2012           | AAO-HNS, ASGE, SAGES          | September 2011 | 118             | 3.51         | NA           | 1.60         | Increase |

- **Tab:** 10
- **Referred to CPT:**
- **Published in CPT Asst:**

| 43195  | Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter) | 000    | Esophagoscopy | MPC List | Yes       | October 2012           | AAO-HNS, ASGE, SAGES          | September 2011 | 493             | 3.07         | NA           | 1.91         | Increase |

- **Tab:** 10
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- **Published in CPT Asst:**
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| **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  **2020 Medicare Utilization**: 1,940 |
| **RUC Recommendation**: 1.89  **Screen**  **Complete?**: Yes |
| **Result**  **MPC List**  **2022 Work RVU**: 1.72  **2022 NF PE RVU**: 9.12  **2022 Fac PE RVU**: 1.07 |
| **Referred to CPT**  **May 2012**  **Published in CPT Asst**  **Referral to 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  **2020 Medicare Utilization**: 17 |
| **RUC Recommendation**: 2.89  **Screen**  **Complete?**: Yes |
| **Result**  **MPC List**  **2022 Work RVU**: 2.33  **2022 NF PE RVU**: NA  **2022 Fac PE RVU**: 1.36 |
| **Referred to CPT**  **May 2012**  **Published in CPT Asst**  **Referral to CPT Asst** |

<p>| <strong>43205</strong>  Esophagoscopy, flexible, transoral; with band ligation of esophageal varices | <strong>Global</strong>: 000  <strong>Issue</strong>: Esophagoscopy  <strong>Screen</strong>: MPC List  <strong>Complete?</strong>: Yes |
| <strong>Most Recent RUC Meeting</strong>: October 2012  <strong>Tab</strong>: 10  <strong>Specialty Developing Recommendation</strong>: AGA, ASGE, SAGES  <strong>First Identified</strong>: September 2011  <strong>2020 Medicare Utilization</strong>: 109 |
| <strong>RUC Recommendation</strong>: 3.00  <strong>Screen</strong>  <strong>Complete?</strong>: Yes |
| <strong>Result</strong>  <strong>MPC List</strong>  <strong>2022 Work RVU</strong>: 2.44  <strong>2022 NF PE RVU</strong>: NA  <strong>2022 Fac PE RVU</strong>: 1.41 |
| <strong>Referred to CPT</strong>  <strong>May 2012</strong>  <strong>Published in CPT Asst</strong>  <strong>Referral to CPT Asst</strong> |</p>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 43219 Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent

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**Most Recent RUC Meeting:** October 2012  
**Tab:** 10  
**Specialty Developing Recommendation:** AGA, ASGE, SAGES  
**First Identified:** September 2011  
**2020 Medicare Utilization:**  
- Work RVU:  
- NF PE RVU:  
- Fac PE RVU:  

**RUC Recommendation:** Deleted from CPT  
**Screen:** MPC List  
**Complete?** Yes

- **Referred to CPT:** May 2012
- **Refered to CPT Asst:** Published in CPT Asst

### 43220 Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)

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**Most Recent RUC Meeting:** October 2012  
**Tab:** 10  
**Specialty Developing Recommendation:** AGA, ASGE, SAGES  
**First Identified:** September 2011  
**2020 Medicare Utilization:**  
- Work RVU: 2.00  
- NF PE RVU: 26.03  
- Fac PE RVU: 1.20

**RUC Recommendation:**  
**Screen:** MPC List  
**Complete?** Yes

- **Referred to CPT:** May 2012
- **Refered 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

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**First Identified:** September 2011  
**2020 Medicare Utilization:**  
- Work RVU: 2.24  
- NF PE RVU: 9.29  
- Fac PE RVU: 1.25

**RUC Recommendation:**  
**Screen:** MPC List  
**Complete?** Yes

- **Referred to CPT:** May 2012
- **Refered to CPT Asst:** Published in CPT Asst

### 43227 Esophagoscopy, flexible, transoral; with control of bleeding, any method

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**2020 Medicare Utilization:**  
- Work RVU: 2.89  
- NF PE RVU: 15.26  
- Fac PE RVU: 1.59

**RUC Recommendation:**  
**Screen:** MPC List  
**Complete?** Yes

- **Referred to CPT:** May 2012
- **Refered to CPT Asst:** Published in CPT Asst

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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**Screen:** Medicare Utilization Screen  
**Referred to CPT:** October 2012  
**Result:** Decrease  
**Published in CPT Asst:** Apr 2009 and Jun 2010

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<td>Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire</td>
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<td><strong>43249</strong>  Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)</td>
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<th><strong>43250</strong>  Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</th>
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**Most Recent RUC Meeting:** April 2013  
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**First Identified:** February 2012  
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**2022 Work RVU:** 4.73  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.43  
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**Referred to CPT:** February 2013  
**Referred to CPT Asst Published in CPT Asst:**

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<td>Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection</td>
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**Most Recent RUC Meeting:** January 2013  
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**2022 Work RVU:** 4.87  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.49  
**Result:** Decrease  
**Referred to CPT:** October 2012  
**Referred to CPT Asst Published in CPT Asst:**

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**2022 NF PE RVU:** 15.52  
**2022 Fac PE RVU:** 1.91  
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>43256</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)</td>
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**Most Recent RUC Meeting:** January 2013  
**Specialty Developing Recommendation:** AGA, ASGE, SAGES  
**First Identified:** September 2011  
**Medicare Utilization:**  
- **2020:** |  
- **2022 Work RVU:**  
- **2022 NF PE RVU:**  
- **2022 Fac PE RVU:**  

**Recommended Action:** Deleted from CPT  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Deleted from CPT

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<td>43257</td>
<td>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</td>
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<td>MPC List</td>
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**Most Recent RUC Meeting:** January 2013  
**Specialty Developing Recommendation:** AGA, ASGE, SAGES  
**First Identified:** September 2011  
**Medicare Utilization:**  
- **2020:** |  
- **2022 Work RVU:** 4.15  
- **2022 NF PE RVU:** NA  
- **2022 Fac PE RVU:** 2.13  

**Recommended Action:**  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Decrease

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<td>43258</td>
<td>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</td>
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<td>EGD</td>
<td>MPC List</td>
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**Most Recent RUC Meeting:** January 2013  
**Specialty Developing Recommendation:** AGA, ASGE, SAGES  
**First Identified:** September 2011  
**Medicare Utilization:**  
- **2020:** |  
- **2022 Work RVU:**  
- **2022 NF PE RVU:**  
- **2022 Fac PE RVU:**  

**Recommended Action:** Deleted from CPT  
**Referred to CPT:** October 2012  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Deleted from CPT
### Status Report: CMS Requests and Relativity Assessment Issues

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#### 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**

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**2022 Work RVU:** 4.04  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.13

**RUC Recommendation:** 4.74

**Referred to CPT:** February 2013  
**Referred to CPT Asst:** Published in CPT Asst: Mar 2009

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#### 43260
**Endoscopic retrograde cholangiopancreatography (ercp); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

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<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
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**2022 Work RVU:** 5.85  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.93

**RUC Recommendation:** 5.95

**Referred to CPT:** February 2013  
**Referred to CPT Asst:** Published in CPT Asst: Mar 2009

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#### 43261
**Endoscopic retrograde cholangiopancreatography (ercp); with biopsy, single or multiple**

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<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
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**2022 Work RVU:** 6.15  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 3.07

**RUC Recommendation:** 6.25

**Referred to CPT:** January 2013  
**Referred to CPT Asst:** Published in CPT Asst: Mar 2009

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**Tuesday, February 1, 2022**  
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td><strong>43262</strong> Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy</td>
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| **43263** Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi | 000 | ERCP | MPC List | Yes |
| Most Recent RUC Meeting: April 2013 | Tab: 12 | Specialty Developing Recommendation: AGA, ASGE, SAGES | First Identified: September 2011 | 2020 Medicare Utilization: 47 |
| Medicare Utilization: | Result: Maintain |

| **43264** Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s) | 000 | ERCP | Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million | Yes |
| Medicare Utilization: | Result: Decrease |
## Status Report: CMS Requests and Relativity Assessment Issues

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<td><strong>Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)</strong>&lt;br&gt;Most Recent RUC Meeting: April 2013 Tab: 12 Specialty Developing Recommendation: AGA, ASGE, SAGES&lt;br&gt;First Identified: September 2011 RUC Recommendation: 8.03&lt;br&gt;2020 Medicare Utilization: 2,379&lt;br&gt;Medicare Utilization: 2022 Work RVU: 7.93&lt;br&gt;2022 NF PE RVU: NA&lt;br&gt;2022 Fac PE RVU: 3.87&lt;br&gt;Result: Decrease&lt;br&gt;Referral to CPT: February 2013&lt;br&gt;Published in CPT Asst:</td>
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<td><strong>Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube</strong>&lt;br&gt;Most Recent RUC Meeting: April 2013 Tab: 12 Specialty Developing Recommendation: AGA, ASGE, SAGES&lt;br&gt;First Identified: September 2011 RUC Recommendation: 12&lt;br&gt;2020 Medicare Utilization:</td>
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Monday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent</td>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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- **Most Recent RUC Meeting:** April 2013
- **Tab:** 12
- **Specialty Developing Recommendation:** AGA, ASGE, SAGES
- **First Identified:** September 2011
- **2020 Medicare Utilization:**
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  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**
- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** February 2013
- **Published in CPT Asst:**

- **Result:** Deleted from CPT

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- **Most Recent RUC Meeting:** April 2013
- **Tab:** 12
- **Specialty Developing Recommendation:** AGA, ASGE, SAGES
- **First Identified:** September 2011
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  - **2022 Fac PE RVU:**
- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** February 2013
- **Published in CPT Asst:**

- **Result:** Deleted from CPT

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- **Most Recent RUC Meeting:** April 2013
- **Tab:** 12
- **Specialty Developing Recommendation:** AGA, ASGE, SAGES
- **First Identified:** September 2011
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- **RUC Recommendation:** 2.24
- **Referred to CPT:** February 2013
- **Published in CPT Asst:**

- **Result:** Maintain
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## 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

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- **RUC Recommendation: 7.11**
- **Result: Decrease**

### 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

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- **RUC Recommendation: 8.08**
- **Result: Decrease**

### 43450 Dilation of esophagus, by unguided sound or bougie, single or multiple passes

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- **RUC Recommendation: 1.30**
- **Result: Decrease**

### 43453 Dilation of esophagus, over guide wire

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- **RUC Recommendation: 1.51**
- **Result: Maintain**
### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
| 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 | **2022 Work RVU:** 1.41 | **2022 NF PE RVU:** 8.92 | **2022 Fac PE RVU:** 0.84 |
| **Most Recent RUC Meeting:** January 2022 | **Tab:** 20 | **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE | **First Identified:** September 2017 | **2020 Medicare Utilization:** 2,006 |
| | | | | **Result:** Decrease |
| **RUC Recommendation:** 1.41. CPT Assistant article. | | | | **Complete** |  |
| **Refereed to CPT** | | | | **Published in CPT Asst:** |

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### Status Report: CMS Requests and Relativity Assessment Issues

#### 44384 Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

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#### 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)

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#### 44386 Endoscopic evaluation of small intestinal pouch (eg, kock pouch, ileal reservoir [s or j]); with biopsy, single or multiple

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

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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**RUC Meeting: January 2014**

**Tab:** 08  
**Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG

**First Identified:** September 2011

**2020 Medicare Utilization:**

- **2022 Work RVU:**
- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**

**Published in CPT Asst:**

**Referred to CPT:** October 2013

**Result:**

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Specialty Developing Recommendation: ACS, ASCRS, SAGES</td>
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### 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)

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<th>Complete?</th>
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**Most Recent RUC Meeting:** October 2013  
**Tab:** 06  
**Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 40,039  
**2022 Work RVU:** 0.84  
**2022 NF PE RVU:** 4.72  
**2022 Fac PE RVU:** 0.69

**RUC Recommendation:** 0.84  
**Result:** Decrease

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

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#### 45331  Sigmoidoscopy, flexible; with biopsy, single or multiple

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**Most Recent RUC Meeting:** October 2013  
**Tab:** 06  
**Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 28,866  
**2022 Work RVU:** 1.14  
**2022 NF PE RVU:** 7.58  
**2022 Fac PE RVU:** 0.83

**RUC Recommendation:** 1.14  
**Result:** Decrease

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

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#### 45332  Sigmoidoscopy, flexible; with removal of foreign body(s)

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**Most Recent RUC Meeting:** October 2013  
**Tab:** 06  
**Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 279  
**2022 Work RVU:** 1.76  
**2022 NF PE RVU:** 6.51  
**2022 Fac PE RVU:** 1.09

**RUC Recommendation:** 1.85  
**Result:** Decrease

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

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#### 45333  Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

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</table>

**Most Recent RUC Meeting:** October 2013  
**Tab:** 06  
**Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 480  
**2022 Work RVU:** 1.55  
**2022 NF PE RVU:** 8.40  
**2022 Fac PE RVU:** 0.98

**RUC Recommendation:** 1.65  
**Result:** Decrease

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:
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<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<tr>
<td>45334</td>
<td>Sigmoidoscopy, flexible; with control of bleeding, any method</td>
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<td><strong>First Identified:</strong> September 2011 <strong>2020 Medicare Utilization:</strong> 2,921</td>
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<td>45335</td>
<td>Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance</td>
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<td>Flexible Sigmoidoscopy</td>
<td>MPC List</td>
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<td>45337</td>
<td>Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed</td>
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<td>MPC List</td>
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<td>Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Screen</th>
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<td>45339</td>
<td>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</td>
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<td>Flexible Sigmoidoscopy</td>
<td>MPC List</td>
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- **Most Recent RUC Meeting:** October 2013
- **Tab:** 06
- **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES
- **First Identified:** September 2011
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**
- **Referred to CPT:** May 2013
- **Published in CPT Asst:**

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<tbody>
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<td>45340</td>
<td>Sigmoidoscopy, flexible; with transendoscopic balloon dilation</td>
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- **Most Recent RUC Meeting:** October 2013
- **Tab:** 06
- **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES
- **First Identified:** September 2011
- **2020 Medicare Utilization:**
  - **2022 Work RVU:** 1.25
  - **2022 NF PE RVU:** 12.88
  - **2022 Fac PE RVU:** 0.86
- **Referred to CPT:** May 2013
- **Published in CPT Asst:**

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<tr>
<td>45341</td>
<td>Sigmoidoscopy, flexible; with endoscopic ultrasound examination</td>
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<td>MPC List</td>
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- **Most Recent RUC Meeting:** January 2014
- **Tab:** 09
- **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS
- **First Identified:** September 2011
- **2020 Medicare Utilization:**
  - **2022 Work RVU:** 2.12
  - **2022 NF PE RVU:** NA
  - **2022 Fac PE RVU:** 1.27
- **Referred to CPT:** October 2013
- **Published in CPT Asst:**

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<td>45342</td>
<td>Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)</td>
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<td>Flexible Sigmoidoscopy</td>
<td>MPC List</td>
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- **Most Recent RUC Meeting:** January 2014
- **Tab:** 09
- **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS
- **First Identified:** September 2011
- **2020 Medicare Utilization:**
  - **2022 Work RVU:** 2.98
  - **2022 NF PE RVU:** NA
  - **2022 Fac PE RVU:** 1.65
- **Referred to CPT:** October 2013
- **Published in CPT Asst:**

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<td>Status Report: CMS Requests and Relativity Assessment Issues</td>
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<tr>
<td><strong>45345</strong></td>
<td>Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)</td>
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<tr>
<td><strong>45346</strong></td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
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<tr>
<td><strong>45347</strong></td>
<td>Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
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<td><strong>Most Recent</strong></td>
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<td>RUC Recommendation: 2.98</td>
<td>Referred to CPT May 2013</td>
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<tr>
<td><strong>45349</strong></td>
<td>Sigmoidoscopy, flexible; with endoscopic mucosal resection</td>
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<td>RUC Recommendation: 3.83</td>
<td>Referred to CPT October 2013</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 45350  Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)

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<td>Flexible Sigmoidoscopy</td>
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**Most Recent RUC Meeting:** April 2014  
**Tab:** 13  
**Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS  
**First Identified:** January 2014  
**RUC Recommendation:** 1.78  
**Referred to CPT:** October 2013  
**Referred to CPT Asst:** Published in CPT Asst  
**Result:** Decrease  

### 45355  Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple

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<td>Colonoscopy via stoma</td>
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**Most Recent RUC Meeting:** January 2014  
**Tab:** 08  
**Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS  
**First Identified:** September 2011  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** February 2014  
**Referred to CPT Asst:** Published in CPT Asst  
**Result:** Deleted from CPT

### 45378  Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

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<td>CMS High Expenditure Procedural Codes 1 / MPC List</td>
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**Most Recent RUC Meeting:** January 2014  
**Tab:** 10  
**Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES  
**First Identified:** September 2011  
**RUC Recommendation:** 3.36  
**Referred to CPT:** October 2013  
**Referred to CPT Asst:** Published in CPT Asst  
**Result:** Decrease

### 45379  Colonoscopy, flexible; with removal of foreign body(s)

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<td>Colonoscopy</td>
<td>MPC List</td>
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**Most Recent RUC Meeting:** January 2014  
**Tab:** 10  
**Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES  
**First Identified:** September 2011  
**RUC Recommendation:** 4.37  
**Referred to CPT:** October 2013  
**Referred to CPT Asst:** Published in CPT Asst  
**Result:** Decrease
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Colonoscopy, flexible; with biopsy, single or multiple</td>
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<td>45381</td>
<td>Colonoscopy, flexible; with directed submucosal injection(s), any substance</td>
<td>MPC List</td>
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<td>45382</td>
<td>Colonoscopy, flexible; with control of bleeding, any method</td>
<td>MPC List</td>
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### 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
- **2020 Medicare Utilization**: 811,967
- **2022 Work RVU**: 3.56
- **2022 NF PE RVU**: 9.33
- **2022 Fac PE RVU**: 1.89
- **Result**: Decrease
- **MPC List / Codes Reported Together 75% or More-Part4**:

#### RUC Recommendation: 3.66

- **Referred to CPT**: October 2013
- **Published in CPT Asst**:

### 45381 Colonoscopy, flexible; with directed submucosal injection(s), any substance

- **Global**: 000
- **Issue**: Colonoscopy
- **Screen**: CMS Fastest Growing

#### Most Recent RUC Meeting: January 2018

- **Tab**: 31
- **Specialty Developing Recommendation**: AGA, ASGE, ACG, ASCRS, ACS, SAGES
- **First Identified**: October 2008
- **2020 Medicare Utilization**: 63,277
- **2022 Work RVU**: 3.56
- **2022 NF PE RVU**: 9.60
- **2022 Fac PE RVU**: 1.89
- **Result**: Decrease
- **Published in CPT Asst**: Jun 2010

#### Referred to CPT

- **Referred to CPT Asst**:

### 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
- **2020 Medicare Utilization**: 21,198
- **2022 Work RVU**: 4.66
- **2022 NF PE RVU**: 15.39
- **2022 Fac PE RVU**: 2.39
- **Result**: Decrease
- **Published in CPT Asst**:

#### Referred to CPT

- **Referred to CPT Asst**:

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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<td>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</td>
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<td>Colonoscopy</td>
<td>MPC List</td>
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| 45384 | Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps | AGA, ASGE, ACG, ASCRS, ACS, SAGES | Colonoscopy | MPC List | Yes |
| **Most Recent RUC Meeting:** January 2014 | **Specialty Developing Recommendation:** | **First Identified:** September 2011 | **2020 Medicare Utilization:** | **2022 Work RVU:** | **2022 NF PE RVU:** | **2022 Fac PE RVU:** |
| Tab: 10 | Reflected to CPT | October 2013 | 2020 | 4.07 | 10.30 | 2.03 |
| RUC Recommendation: 4.17 | Published in CPT Asst: | | | | | |

| 45385 | Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique | AGA, ASGE, ACG, ASCRS, SAGES | Colonoscopy | MPC List / Codes Reporting Together 75% or More-Part4 / CMS Request - Final Rule for 2019 | Yes |
| **Most Recent RUC Meeting:** April 2019 | **Specialty Developing Recommendation:** | **First Identified:** October 2010 | **2020 Medicare Utilization:** | **2022 Work RVU:** | **2022 NF PE RVU:** | **2022 Fac PE RVU:** |
| Tab: 13 | Reflected to CPT | October 2013 | 2020 | 4.57 | 8.72 | 2.34 |
| RUC Recommendation: 4.57 | Published in CPT Asst: | | | | | |
#### 45386 Colonoscopy, flexible; with transendoscopic balloon dilation

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**Most Recent RUC Meeting:** January 2014  
**RUC Recommendation:** 3.87  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 1,879  
**2022 Work RVU:** 3.77  
**2022 NF PE RVU:** 14.69  
**2022 Fac PE RVU:** 1.97  
**Result:** Decrease

**Referred to CPT:** October 2013  
**Published in CPT Asst:**

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#### 45387 Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)

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**Most Recent RUC Meeting:** January 2014  
**RUC Recommendation:** Deleted from CPT  
**First Identified:** September 2011  
**2020 Medicare Utilization:**

**Referred to CPT:** October 2013  
**Published in CPT Asst:**

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#### 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)

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**Most Recent RUC Meeting:** January 2014  
**RUC Recommendation:** 4.98  
**First Identified:** January 2014  
**2020 Medicare Utilization:** 19,852  
**2022 Work RVU:** 4.88  
**2022 NF PE RVU:** 72.13  
**2022 Fac PE RVU:** 2.43  
**Result:** Decrease

**Referred to CPT:** October 2013  
**Published in CPT Asst:**

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#### 45389 Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)

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**Most Recent RUC Meeting:** January 2014  
**RUC Recommendation:** 5.50  
**First Identified:** January 2014  
**2020 Medicare Utilization:** 425  
**2022 Work RVU:** 5.24  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.64  
**Result:** Decrease

**Referred to CPT:** October 2013  
**Published in CPT Asst:**
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## 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

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| RUC Recommendation: | 4.78 |
| Referred to CPT | October 2013 |
| Published in CPT Asst: | |

### 45398 Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)

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| RUC Recommendation: | 4.30 |
| Referred to CPT | October 2013 |
| Published in CPT Asst: | |

### 46020 Placement of seton

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| RUC Recommendation: | 3.50 |
| Referred to CPT | |
| Published in CPT Asst: | |

### 46030 Removal of anal seton, other marker

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| RUC Recommendation: | 2.00 |
| Referred to CPT | |
| 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

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- **Result:** PE Only

#### 46500 Injection of sclerosing solution, hemorrhoids

- **Global:** 010
- **Issue:** Hemorrhoid Injection
- **Screen:** 010-Day Global Post-Operative Visits / Negative IWPUT
- **Complete?** Yes

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- **Result:** Increase

#### 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

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- **Result:** Deleted from CPT
### Status Report: CMS Requests and Relativity Assessment Issues

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# Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>balloon dilation, catheter exchange(s) and catheter removal(s) when</td>
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<td>new access, without placement of separate biliary drainage catheter</td>
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| 47540    | Placement of stent(s) into a bile duct, percutaneous, including diagnostic  | 000    | Percutaneous Biliary Procedures     | Codes Reported Together 75%  | Yes       |
|          | cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound),      | Issue  | Bundling                           | or More-Part2                |           |
|          | 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)                                             |        |                                    |                              |           |
|          | Most Recent RUC Meeting: October 2015                                      |        |                                    |                              |           |
|          | Specialty Developing Recommendation: ACR, SIR                               |        |                                    |                              |           |
|          | First Identified: February 2015                                            |        |                                    |                              |           |
|          | 2020 Medicare Utilization: 215                                              |        |                                    |                              |           |
|          | 2022 Work RVU: 9.03                                                        |        |                                    |                              |           |
|          | 2022 NF PE RVU: 123.24                                                     |        |                                    |                              |           |
|          | 2022 Fac PE RVU: 2.83                                                      |        |                                    |                              |           |
|          | Referred to CPT February 2015                                              |        |                                    |                              |           |
|          | Result: Increase                                                            |        |                                    |                              |           |

| 47541    | Placement of access through the biliary tree and into small bowel to        | 000    | Percutaneous Biliary Procedures     | Codes Reported Together 75%  | Yes       |
|          | assist with an endoscopic biliary procedure (eg, rendezvous procedure),     | Issue  | Bundling                           | or More-Part2                |           |
|          | percutaneous, including diagnostic cholangiography when performed, imaging  |        |                                    |                              |           |
|          | guidance (eg, ultrasound and/or fluoroscopy), and all associated            |        |                                    |                              |           |
|          | radiological supervision and interpretation, new access                     |        |                                    |                              |           |
|          | Most Recent RUC Meeting: October 2015                                      |        |                                    |                              |           |
|          | Specialty Developing Recommendation: ACR, SIR                               |        |                                    |                              |           |
|          | First Identified: February 2015                                            |        |                                    |                              |           |
|          | 2020 Medicare Utilization: 159                                              |        |                                    |                              |           |
|          | 2022 Work RVU: 6.75                                                        |        |                                    |                              |           |
|          | 2022 NF PE RVU: 28.35                                                      |        |                                    |                              |           |
|          | 2022 Fac PE RVU: 2.26                                                      |        |                                    |                              |           |
|          | Referred to CPT February 2015                                              |        |                                    |                              |           |
|          | Result: Increase                                                            |        |                                    |                              |           |
### Status Report: CMS Requests and Relativity Assessment Issues

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**Note:**
- **Screen:** CMS Request - Final Rule for 2012
- **Complete?:** Yes
- **Tab:** 36
- **Specialty Developing Recommendation:** ACS, SAGES
- **First Identified:** September 2011
- **2020 Medicare Utilization:** 6,677
- **2022 Work RVU:** 17.48
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 10.19
- **Result:** Increase
- **Tab:** 36
- **Specialty Developing Recommendation:** ACS, SAGES
- **First Identified:** September 2011
- **2020 Medicare Utilization:** 1,050
- **2022 Work RVU:** 18.48
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 10.65
- **Result:** Increase
- **Tab:** 16
- **Specialty Developing Recommendation:** SIR
- **First Identified:** September 2007
- **2020 Medicare Utilization:** 836
- **2022 Work RVU:** 4.70
- **2022 NF PE RVU:** 10.59
- **2022 Fac PE RVU:** 1.74
- **Result:** PE Only
## Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance

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**Most Recent RUC Meeting:** October 2010

**Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2020 Medicare Utilization:** 10,481

**2022 Work RVU:** 1.24

**2022 NF PE RVU:** 5.05

**2022 Fac PE RVU:** 0.73

**Referred to CPT:** June 2010

**Result:** Decrease

---

### 49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>000</td>
<td>Abdominal Paracentesis</td>
<td>Harvard Valued - Utilization over 100,000</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** October 2010

**Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2020 Medicare Utilization:** 252,899

**2022 Work RVU:** 2.00

**2022 NF PE RVU:** 6.78

**2022 Fac PE RVU:** 0.91

**Referred to CPT:** June 2010

**Result:** Decrease

---

### 49084 Peritoneal lavage, including imaging guidance, when performed

<table>
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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
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<td>000</td>
<td>Abdominal Paracentesis</td>
<td>Harvard Valued - Utilization over 100,000</td>
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**Most Recent RUC Meeting:** October 2010

**Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2020 Medicare Utilization:** 1,630

**2022 Work RVU:** 2.00

**2022 NF PE RVU:** NA

**2022 Fac PE RVU:** 0.74

**Referred to CPT:** June 2010

**Result:** Increase
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>RVU</th>
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<td>Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous</td>
<td>000</td>
<td>Drainage of Abscess</td>
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| 49406   | Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous | 000    | Drainage of Abscess |                                                     | Yes       |       | 30,881               | 2022    |
|         |                                                                               |        |                     |                                                     |           | 2020  | 2022 NF PE RVU: 23.05 |         |
|         |                                                                               |        |                     |                                                     |           |       | 2022 Fac PE RVU: 1.30 |         |
| RUC Recommendation: 4.25 | Referred to CPT October 2012 | 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 | 000    | Drainage of Abscess |                                                     | Yes       |       | 194                 | 2022    |
|         |                                                                               |        |                     |                                                     |           | 2020  | 2022 NF PE RVU: 18.40 |         |
|         |                                                                               |        |                     |                                                     |           |       | 2022 Fac PE RVU: 1.33 |         |
| RUC Recommendation: 4.50 | Referred to CPT October 2012 | Referred to CPT Asst | Published in CPT Asst: | | | | | |
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>49418</td>
<td>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</td>
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<td>49421</td>
<td>Insertion of tunneled intraperitoneal catheter for dialysis, open</td>
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<td>4.21</td>
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**Most Recent RUC Meeting:**
- April 2010
- October 2009
- April 2010

**Tab:**
- 11
- 40
- 11

**Specialty Developing Recommendation:**
- ACS, ACR, SIR
- ACS
- ACS, ACR, SIR

**First Identified:**
- February 2010
- April 2008
- September 2007

**RUC Recommendation:**
- 4.21
- Deleted from CPT
- 4.21

**Referred to CPT:**
- February 2010
- February 2008
- February 2010

**Referred to CPT Asst Published in CPT Asst:**
- Yes
- Yes
- Yes

**Medicare Utilization:**
- Decrease
- Decrease
- Decrease

**Result:**
- Decrease
- Deleted from CPT
- Decrease
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<th><strong>49436</strong>  Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter</th>
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<td><strong>First Identified:</strong> November 2021  <strong>2020 Medicare Utilization:</strong> 297</td>
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<td><strong>Global:</strong> 090  <strong>Issue:</strong> Hernia Repair</td>
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<td><strong>Screen:</strong> Site of Service Anomaly  <strong>Complete?</strong> Yes</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Year</th>
<th>NF PE RVU</th>
<th>Fac PE RVU</th>
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<td>49521</td>
<td>Repair recurrent inguinal hernia, any age; incarcerated or strangulated</td>
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<td>Hernia Repair</td>
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<td>2022</td>
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</table>

| 49560    | Repair initial incisional or ventral hernia; reducible                           | 090    | Anterior Abdominal Hernia Repair | Site of Service Anomaly | Yes       | 2022 | 11.92     | 7.23       |
|          | Most Recent RUC Meeting: April 2021                                             |        |       |        |           |      |           |            |
|          | Tab: 09 Specialty Developing Recommendation: ACS, ASCRS (col), SAGES             |        |       |        |           |      |           |            |
|          | First Identified: February 2021                                                 |        |       |        |           |      |           |            |
|          | RUC Recommendation: Deleted from CPT                                             |        |       |        |           |      |           |            |
|          | Referred to CPT                                                                  |        |       |        |           |      |           |            |
|          | Referred to CPT Asst                                                             |        |       |        |           |      |           |            |
|          | Published in CPT Asst                                                            |        |       |        |           |      |           |            |

| 49561    | Repair initial incisional or ventral hernia; incarcerated or strangulated         | 090    | Anterior Abdominal Hernia Repair | Site of Service Anomaly | Yes       | 2022 | 15.38     | 8.59       |
|          | Most Recent RUC Meeting: April 2021                                             |        |       |        |           |      |           |            |
|          | Tab: 09 Specialty Developing Recommendation: ACS, ASCRS (col), SAGES             |        |       |        |           |      |           |            |
|          | First Identified: February 2021                                                 |        |       |        |           |      |           |            |
|          | RUC Recommendation: Deleted from CPT                                             |        |       |        |           |      |           |            |
|          | Referred to CPT                                                                  |        |       |        |           |      |           |            |
|          | Referred to CPT Asst                                                             |        |       |        |           |      |           |            |
|          | Published in CPT Asst                                                            |        |       |        |           |      |           |            |

| 49565    | Repair recurrent incisional or ventral hernia; reducible                          | 090    | Anterior Abdominal Hernia Repair | Site of Service Anomaly | Yes       | 2022 | 12.37     | 7.58       |
|          | Most Recent RUC Meeting: April 2021                                             |        |       |        |           |      |           |            |
|          | Tab: 09 Specialty Developing Recommendation: ACS, ASCRS (col), SAGES             |        |       |        |           |      |           |            |
|          | First Identified: October 2019                                                   |        |       |        |           |      |           |            |
|          | RUC Recommendation: Deleted from CPT                                             |        |       |        |           |      |           |            |
|          | Referred to CPT                                                                  |        |       |        |           |      |           |            |
|          | Referred to CPT Asst                                                             |        |       |        |           |      |           |            |
|          | Published in CPT Asst                                                            |        |       |        |           |      |           |            |
### Status Report: CMS Requests and Relativity Assessment Issues

#### 49566  Repair recurrent incisional or ventral hernia; incarcerated or strangulated

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<th>Issue</th>
<th>Screen</th>
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<tbody>
<tr>
<td>090</td>
<td>Anterior Abdominal Hernia Repair</td>
<td>Site of Service Anomaly - 2019</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** April 2021  
**Tab:** 09  
**Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES  
**First Identified:** February 2021  
**2020 Medicare Utilization:** 2,899  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT Asst:** Published in CPT Asst:

**Result:** Deleted from CPT

#### 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)

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<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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**Most Recent RUC Meeting:** April 2021  
**Tab:** 09  
**Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES  
**First Identified:** February 2021  
**2020 Medicare Utilization:** 20,800  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT Asst:** Published in CPT Asst:

**Result:** Deleted from CPT

#### 49570  Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)

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<th>Issue</th>
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**Most Recent RUC Meeting:** April 2021  
**Tab:** 09  
**Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES  
**First Identified:** February 2021  
**2020 Medicare Utilization:** 461  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT Asst:** Published in CPT Asst:

**Result:** Deleted from CPT
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>2022 Fac PE RVU: 5.73</td>
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<td>49580</td>
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<td>Site of Service Anomaly - 2019</td>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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# Status Report: CMS Requests and Relativity Assessment Issues

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| | | | | | Referred to CPT February 2021 | Result: Decrease |
| | | | | | Referred to CPT Asst | Published in CPT Asst: |

| | RUC Recommendation: 16.97 | | | 2020 Medicare Utilization: | 2022 Work RVU: | |
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| | | | | | Referred to CPT Asst | Published in CPT Asst: |

| 49X12 | Most Recent RUC Meeting: April 2021 | Tab: 09 | Specialty Developing Recommendation: ACS, ASCRS (col), SAGES | First Identified: February 2021 | Screen: Site of Service Anomaly - 2019 | Complete? Yes |
| | RUC Recommendation: 24.00 | | | 2020 Medicare Utilization: | 2022 Work RVU: | |
| | | | | | 2022 NF PE RVU: | |
| | | | | | 2022 Fac PE RVU: | |
| | | | | | Referred to CPT February 2021 | Result: Decrease |
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### Status Report: CMS Requests and Relativity Assessment Issues

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#### Issue Details:

**49X13n**

- **Global:**
- **Issue:** Anterior Abdominal Hernia Repair
- **Screen:** Site of Service Anomaly
- **Complete?** Yes

**RUC Recommendation:** 14.24

- **First Identified:** February 2021
- **Referred to CPT:** February 2021
- **Result:** Decrease
- **Referred to CPT Asst:**

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**49X14**

- **Global:**
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- **Screen:** Site of Service Anomaly
- **Complete?** Yes

**RUC Recommendation:** 18.00

- **First Identified:** February 2021
- **Referred to CPT:** February 2021
- **Result:** Decrease
- **Referred to CPT Asst:**

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**49X15**

- **Global:**
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- **Screen:** Site of Service Anomaly
- **Complete?** Yes

**RUC Recommendation:** 5.00

- **First Identified:** February 2021
- **Referred to CPT:** February 2021
- **Result:** Decrease
- **Referred to CPT Asst:**
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Tuesday, February 1, 2022
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<td>50394</td>
<td>Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** January 2018  
**Tab:** 12  
**Specialty Developing Recommendation:** ACR, SIR  
**First Identified:** October 2014  
**2020 Medicare Utilization:**  
**Result:** Deleted from CPT  
**Deleted from CPT**

### 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  
**2020 Medicare Utilization:**  
**Result:** Deleted from CPT  
**Deleted from CPT**

### 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  
**2020 Medicare Utilization:** 915  
**Result:** Increase  
**Increase**
### Status Report: CMS Requests and Relativity Assessment Issues

#### 50431
Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

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| RUC Recommendation: 1.42 | Referred to CPT October 2014 | Referred to CPT Asst | Published in CPT Asst: |

#### 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

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| RUC Recommendation: 4.00 | Referred to CPT October 2014 | 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

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| RUC Recommendation: 5.05 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: |

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<td>50435</td>
<td>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</td>
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<td>50436</td>
<td>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;</td>
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**Status Report: CMS Requests and Relativity Assessment Issues**

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### Status Report: CMS Requests and Relativity Assessment Issues

**50590  Lithotripsy, extracorporeal shock wave**

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<td><strong>First Identified:</strong> September 2011</td>
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**Referred to CPT Asst**
**Published in CPT Asst:**

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**50605  Ureterotomy for insertion of indwelling stent, all types**

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

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**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)**

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

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**Notes:**
- Lithotripsy, extracorporeal shock wave
- Ureterotomy for insertion of indwelling stent, all types
- 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)
### Status Report: CMS Requests and Relativity Assessment Issues

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<tbody>
<tr>
<td>50693</td>
<td>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</td>
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<td>50694</td>
<td>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</td>
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<tr>
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<td>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</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 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)

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<td>Genitourinary Catheter Procedures</td>
<td>Codes Reported Together 75% or More-Part2</td>
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#### Most Recent RUC Meeting:
- April 2015

#### Specialty Developing Recommendation:
- ACR, SIR

#### First Identified:
- October 2014

#### 2020 Medicare Utilization:
- 63

#### RUC Recommendation:
- 4.03

#### Result:
- Increase

#### Referred to CPT:
- October 2014

#### Published in CPT Asst:
- No

### 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)

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#### Most Recent RUC Meeting:
- April 2015

#### Specialty Developing Recommendation:
- ACR, SIR

#### First Identified:
- October 2014

#### 2020 Medicare Utilization:
- 1,346

#### RUC Recommendation:
- 3.80

#### Result:
- Increase

#### Referred to CPT:
- October 2014

#### Published in CPT Asst:
- No

### 51040 Cystostomy, cystotomy with drainage

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<td>Site of Service Anomaly (99238-Only)</td>
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#### Most Recent RUC Meeting:
- September 2007

#### Specialty Developing Recommendation:
- AUA

#### First Identified:
- September 2007

#### 2020 Medicare Utilization:
- 3,927

#### RUC Recommendation:
- Reduce 99238 to 0.5

#### Result:
- PE Only

#### Referred to CPT:
- 

#### Published in CPT Asst:
- No
# Status Report: CMS Requests and Relativity Assessment Issues

## 51102  Aspiration of bladder; with insertion of suprapubic catheter

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## 51700  Bladder irrigation, simple, lavage and/or instillation

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## 51701  Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)

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## 51702  Insertion of temporary indwelling bladder catheter; simple (eg, foley)

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)</td>
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<td><strong>Result:</strong> Maintain</td>
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</table>

| 51720    | Bladder instillation of anticarcinogenic agent (including retention time)          | 000    | Treatment of Bladder Lesion | CMS High Expenditure Procedural Codes2 | Yes       |        |
|          | **Most Recent RUC Meeting:** January 2016 **Tab:** 33                             |        |             |                                                                         |           |        |
|          | **Specialty Developing Recommendation:** AUA                                       |        |             |                                                                         |           |        |
|          | **First Identified:** July 2015                                                   |        |             |                                                                         |           |        |
|          | **2020 Medicare Utilization:** 154,326                                              |        |             |                                                                         |           |        |
|          | **2022 Work RVU:** 0.87                                                           |        |             |                                                                         |           |        |
|          | **2022 NF PE RVU:** 1.62                                                           |        |             |                                                                         |           |        |
|          | **2022 Fac PE RVU:** 0.30                                                          |        |             |                                                                         |           |        |
|          | **RUC Recommendation:** 0.87                                                       |        |             |                                                                         |           |        |
|          | **Referred to CPT**                                                               |        |             |                                                                         |           |        |
|          | **Yes**                                                                           |        |             |                                                                         |           |        |
|          | **Referred to CPT Asst:**                                                         |        |             |                                                                         |           |        |
|          | **Published in CPT Asst:**                                                        |        |             |                                                                         |           |        |
|          | **Result:** Decrease                                                              |        |             |                                                                         |           |        |

| 51726    | Complex cystogram (ie, calibrated electronic equipment);                            | 000    | Urodynamic Studies | Codes Reported Together 95% or More | Yes       |        |
|          | **Most Recent RUC Meeting:** April 2009 **Tab:** 16                               |        |             |                                                                         |           |        |
|          | **Specialty Developing Recommendation:** AUA, ACOG                                |        |             |                                                                         |           |        |
|          | **First Identified:** February 2008                                              |        |             |                                                                         |           |        |
|          | **2020 Medicare Utilization:** 3,276                                              |        |             |                                                                         |           |        |
|          | **2022 Work RVU:** 1.71                                                           |        |             |                                                                         |           |        |
|          | **2022 NF PE RVU:** 7.24                                                           |        |             |                                                                         |           |        |
|          | **2022 Fac PE RVU:** NA                                                            |        |             |                                                                         |           |        |
|          | **RUC Recommendation:** 1.71                                                       |        |             |                                                                         |           |        |
|          | **Referred to CPT**                                                               |        |             |                                                                         |           |        |
|          | **February 2009**                                                                 |        |             |                                                                         |           |        |
|          | **Referred to CPT Asst:**                                                         |        |             |                                                                         |           |        |
|          | **Published in CPT Asst:**                                                        |        |             |                                                                         |           |        |
|          | **Result:** Maintain                                                              |        |             |                                                                         |           |        |

| 51727    | Complex cystogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique | 000    | Urodynamic Studies | Codes Reported Together 95% or More | Yes       |        |
|          | **Most Recent RUC Meeting:** April 2009 **Tab:** 16                               |        |             |                                                                         |           |        |
|          | **Specialty Developing Recommendation:** AUA, ACOG                                |        |             |                                                                         |           |        |
|          | **First Identified:** February 2009                                              |        |             |                                                                         |           |        |
|          | **2020 Medicare Utilization:** 1,347                                              |        |             |                                                                         |           |        |
|          | **2022 Work RVU:** 2.11                                                           |        |             |                                                                         |           |        |
|          | **2022 NF PE RVU:** 8.66                                                           |        |             |                                                                         |           |        |
|          | **2022 Fac PE RVU:** NA                                                            |        |             |                                                                         |           |        |
|          | **RUC Recommendation:** 2.11                                                       |        |             |                                                                         |           |        |
|          | **Referred to CPT**                                                               |        |             |                                                                         |           |        |
|          | **February 2009**                                                                 |        |             |                                                                         |           |        |
|          | **Referred to CPT Asst:**                                                         |        |             |                                                                         |           |        |
|          | **Published in CPT Asst:**                                                        |        |             |                                                                         |           |        |
|          | **Result:** Decrease                                                              |        |             |                                                                         |           |        |
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td><strong>51736</strong></td>
<td>Simple uroflowmetry (ufr) (eg, stop-watch flow rate, mechanical uroflowmeter)</td>
<td>XXX</td>
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</table>
# Status Report: CMS Requests and Relativity Assessment Issues

## 51741 Complex uroflowmetry (eg, calibrated electronic equipment)

**Global:** XXX  
**Issue:** Uroflowmetry  
**Screen:** Harvard Valued - Utilization over 100,000  
**Complete?** Yes

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**RUC Recommendation: 0.17**  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

**Result:**

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**RUC Recommendation: Deleted from CPT**  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

**Result:**

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## 51784 Electromyography studies (emg) of anal or urethral sphincter, other than needle, any technique

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**RUC Recommendation: 0.75. Maintain, CPT Assistant addressed issues identified.**  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

**Result:**

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Tuesday, February 1, 2022  
Page 335 of 836
## Status Report: CMS Requests and Relativity Assessment Issues

**51792**  
**Stimulus evoked response (e.g., measurement of bulbocavernosus reflex latency time)**  
<table>
<thead>
<tr>
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<th>Issue: Urinary Reflex Studies with EMG</th>
<th>Screen: Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018</th>
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**51795**  
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**51797**  
**Voiding pressure studies, intra-abdominal (i.e., rectal, gastric, intraperitoneal) (list separately in addition to code for primary procedure)**  
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## Status Report: CMS Requests and Relativity Assessment Issues

### 51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

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**Referred to CPT**

**Published in CPT Asst:**

### 52000 Cystourethroscopy (separate procedure)

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**Referred to CPT**

**Published in CPT Asst:**

### 52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

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**Referred to CPT**

**Published in CPT Asst:** Aug 2009 and May 2016
## Cystourethroscopy

### 52224

- **Global:** 000
- **Issue:** Cystourethroscopy
- **Screen:** High Volume Growth
- **Complete?** Yes

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### 52234

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

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### 52235

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

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<td>52281</td>
<td>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</td>
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<td>52287</td>
<td>Cystourethroscopy, with injection(s) for chemodenervation of the bladder</td>
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<tr>
<td>52332 Cystourethroscopy, with insertion of indwelling ureteral stent</td>
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<td>(eg, gibbons or double-j type)</td>
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<td>52334 Cystourethroscopy with insertion of ureteral guide wire</td>
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<td>through kidney to establish a percutaneous nephrostomy, retrograde</td>
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<td>52342</td>
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<td>52344</td>
<td>Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
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| 52351   | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic                                                                          | 000    | Urological Proce | Harvard Valued - Utilization over 30,000 | Yes       |
|         | Most Recent RUC Meeting: September 2011                                                                                                     |        |               |                                       |           |
|         | Specialty Developing Recommendation: AUA                                                                                                     |        |               |                                       |           |
|         | First Identified: September 2011                                                                                                             |        |               |                                       |           |
|         | 2020 Medicare Utilization: 21,257                                                                                                             |        |               |                                       |           |
|         | 2022 Work RVU: 5.75 2022 Fac PE RVU: 2.33                                                                                                    |        |               |                                       |           |
|         | RUC Recommendation: 5.75                                                                                                                    |        |               |                                       |           |
|         | Result: Decrease                                                                                                                             |        |               |                                       |           |
|         | Referred to CPT 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) | 000    | Urological Proce | Harvard Valued - Utilization over 30,000 | Yes       |
|         | Most Recent RUC Meeting: September 2011                                                                                                     |        |               |                                       |           |
|         | Specialty Developing Recommendation: AUA                                                                                                     |        |               |                                       |           |
|         | First Identified: September 2011                                                                                                             |        |               |                                       |           |
|         | 2020 Medicare Utilization: 21,065                                                                                                             |        |               |                                       |           |
|         | 2022 Work RVU: 6.75 2022 Fac PE RVU: 2.71                                                                                                    |        |               |                                       |           |
|         | RUC Recommendation: 6.75                                                                                                                    |        |               |                                       |           |
|         | Result: Decrease                                                                                                                             |        |               |                                       |           |
|         | Referred to CPT Referred to CPT Asst Published in CPT Asst:                                                                                  |        |               |                                       |           |
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>52400</th>
<th>Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds</th>
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<th>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure)</th>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Transurethral resection of bladder neck (separate procedure)</td>
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**Most Recent RUC Meeting:** October 2010  
**RUC Recommendation:** 8.14

| 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) |        |       |        |           |
|      | Urological Procedures                                                       | 090    |       |        |           |
|      | Site of Service Anomaly                                                     |        |       |        |           |
|      | Referred to CPT                                                             |        |       |        |           |
|      | Published in CPT Asst                                                       |        |       |        |           |
|      | Yes                                                                         |        |       |        |           |

**Most Recent RUC Meeting:** April 2016  
**RUC Recommendation:** 13.16

| 52640| Transurethral resection; of postoperative bladder neck contracture           |        |       |        |           |
|      | Urological Procedures                                                       | 090    |       |        |           |
|      | Site of Service Anomaly                                                     |        |       |        |           |
|      | Referred to CPT                                                             |        |       |        |           |
|      | Published in CPT Asst                                                       |        |       |        |           |
|      | Yes                                                                         |        |       |        |           |

**Most Recent RUC Meeting:** April 2008  
**RUC Recommendation:** 4.79

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Other entries and details related to Medicare utilization and CPT codes provided in the document are not fully transcribed here.
## Status Report: CMS Requests and Relativity Assessment Issues

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<tbody>
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<td>52648</td>
<td>Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatoectomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)</td>
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<td>Transurethral destruction of prostate tissue; by microwave thermotherapy</td>
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<td>Transurethral Destruction of Prostate Tissue</td>
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Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatoectomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
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<td>Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session</td>
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<td>Orchiectomy, radical, for tumor; inguinal approach</td>
<td>090</td>
<td>Urological Procedures</td>
<td>Site of Service Anomaly</td>
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<td>31</td>
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<td>Status Report: CMS Requests and Relativity Assessment Issues</td>
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<tr>
<td><strong>55700</strong> Biopsy, prostate; needle or punch, single or multiple, any approach</td>
<td>Global: 000  Issue: Biopsy of Prostate  Screen: CMS High Expenditure Procedural Codes2  Complete? Yes</td>
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<tr>
<td><strong>55706</strong> Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance</td>
<td>Global: 010  Issue: RAW  Screen: 010-Day Global Post-Operative Visits  Complete? Yes</td>
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<td><strong>55840</strong> Prostatectomy, retropubic radical, with or without nerve sparing;</td>
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<tr>
<td><strong>55842</strong> Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)</td>
<td>Global: 090  Issue:  Screen: CMS Request - Final Rule for 2014  Complete? Yes</td>
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Tuesday, February 1, 2022  Page 348 of 836
<table>
<thead>
<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<tbody>
<tr>
<td><strong>55845</strong> Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes</td>
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<td>Global: 090</td>
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<td>Most Recent RUC Meeting: April 2014</td>
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<tr>
<td>Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes</td>
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<table>
<thead>
<tr>
<th><strong>55866</strong> Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed</th>
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<tbody>
<tr>
<td>2020 Medicare Utilization: 18,557</td>
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<td>Laparoscopic Radical Prostatectomy</td>
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<table>
<thead>
<tr>
<th><strong>55873</strong> Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</th>
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<td>RUC Recommendation: 13.45</td>
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<td>Published in CPT Asst:</td>
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</table>
### Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

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<thead>
<tr>
<th>Global: 090</th>
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<td><strong>55875</strong></td>
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**Most Recent RUC Meeting:** October 2015  
**Tab:** 21  
**Specialty Developing Recommendation:** Review data at RAW  
**First Identified:** April 2015  
**2020 Medicare Utilization:** 5,423

**RUC Recommendation:** Review data at RAW  
**Result:** Not Part of RAW

**2022 Work RVU:** 13.46  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 7.83

---

### Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

<table>
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<tr>
<th>Global: 010</th>
<th>Issue: Destruction of Lesions</th>
<th>Screen: Site of Service Anomaly (99238-Only)</th>
<th>Complete?</th>
<th>Yes</th>
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<tbody>
<tr>
<td><strong>56515</strong></td>
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**Most Recent RUC Meeting:** September 2007  
**Tab:** 16  
**Specialty Developing Recommendation:** ACOG  
**First Identified:** September 2007  
**2020 Medicare Utilization:** 2,247

**RUC Recommendation:** Reduce 99238 to 0.5  
**Result:** PE Only

**2022 Work RVU:** 3.08  
**2022 NF PE RVU:** 4.79  
**2022 Fac PE RVU:** 2.76

---

### Vulvectomy simple; partial

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<thead>
<tr>
<th>Global: 090</th>
<th>Issue: Partial Removal of Vulva</th>
<th>Screen: Site of Service Anomaly</th>
<th>Complete?</th>
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<tbody>
<tr>
<td><strong>56620</strong></td>
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**Most Recent RUC Meeting:** February 2008  
**Tab:** D  
**Specialty Developing Recommendation:** ACOG  
**First Identified:** September 2007  
**2020 Medicare Utilization:** 2,636

**RUC Recommendation:** 7.35  
**Result:** Decrease

**2022 Work RVU:** 7.53  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 8.74

---

### Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease

<table>
<thead>
<tr>
<th>Global: 000</th>
<th>Issue: Vaginal Treatments</th>
<th>Screen: CMS 000-Day Global Typically Reported with an E/M</th>
<th>Complete?</th>
<th>Yes</th>
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<tbody>
<tr>
<td><strong>57150</strong></td>
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**Most Recent RUC Meeting:** April 2017  
**Tab:** 15  
**Specialty Developing Recommendation:** ACOG  
**First Identified:** July 2016  
**2020 Medicare Utilization:** 19,829

**RUC Recommendation:** 0.50  
**Result:** Decrease

**2022 Work RVU:** 0.50  
**2022 NF PE RVU:** 1.20  
**2022 Fac PE RVU:** 0.19
## Status Report: CMS Requests and Relativity Assessment Issues

### 57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
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<tbody>
<tr>
<td>000</td>
<td>RAW</td>
<td>Site of Service Anomaly / Different Performing Specialty from Survey</td>
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**Most Recent RUC Meeting:** January 2017

**Specialty Developing Recommendation:** ACOG, ASTRO

**First Identified:** September 2007

<table>
<thead>
<tr>
<th>Medicare Utilization</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
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<tbody>
<tr>
<td>2,870</td>
<td>5.15</td>
<td>6.05</td>
<td>2.72</td>
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**Referred to CPT:** October 2009

**Published in CPT Asst:**

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### 57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy

<table>
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<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>000</td>
<td>RAW</td>
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**Most Recent RUC Meeting:** January 2017

**Specialty Developing Recommendation:** ACOG, ASTRO

**First Identified:** September 2007

<table>
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<tr>
<td>14,536</td>
<td>2.69</td>
<td>3.84</td>
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**Referred to CPT:** October 2009

**Published in CPT Asst:**

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### 57160 Fitting and insertion of pessary or other intravaginal support device

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<td>Vaginal Treatments</td>
<td>CMS 000-Day Global Typically Reported with an E/M</td>
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**Most Recent RUC Meeting:** April 2017

**Specialty Developing Recommendation:** ACOG

**First Identified:** July 2016

<table>
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<td>68,682</td>
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**Referred to CPT**

**Published in CPT Asst:**

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>57240</td>
<td>Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed</td>
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<td>Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy</td>
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<tr>
<td>57265</td>
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Tuesday, February 1, 2022
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<th>CMS</th>
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<th>Issue</th>
<th>Screen</th>
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<tbody>
<tr>
<td>57282</td>
<td>Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)</td>
<td>090</td>
<td>Colpopexy</td>
<td>Site of Service Anomaly - 2019</td>
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<td>Published in CPT Asst:</td>
<td>Result: Increase</td>
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<td>57283</td>
<td>Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)</td>
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<td>Colpopexy</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 57425 Laparoscopy, surgical, colpopexy (suspension of vaginal apex)

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#### 58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

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#### 58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure)

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# Status Report: CMS Requests and Relativity Assessment Issues

## 58560 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

- **Most Recent RUC Meeting:** January 2016
- **Table:** 37
- **Specialty Developing Recommendation:** ACOG
- **First Identified:** July 2015
- **2020 Medicare Utilization:** 43
- **Complete?** Yes
- **Result:** Decrease

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## 58561 Hysteroscopy, surgical; with removal of leiomyomata

- **Most Recent RUC Meeting:** January 2016
- **Table:** 37
- **Specialty Developing Recommendation:** ACOG
- **First Identified:** July 2015
- **2020 Medicare Utilization:** 1,828
- **Complete?** Yes
- **Result:** Decrease

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## 58562 Hysteroscopy, surgical; with removal of impacted foreign body

- **Most Recent RUC Meeting:** January 2016
- **Table:** 37
- **Specialty Developing Recommendation:** ACOG
- **First Identified:** NA
- **2020 Medicare Utilization:** 204
- **Complete?** Yes
- **Result:** Decrease

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Tuesday, February 1, 2022
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**RUC Meeting:** October 2009  
**Tab:** 15  
**Specialty Developing Recommendation:** ACOG, AAFP  
**First Identified:** April 2008  
**2020 Medicare Utilization:** 69

- **RUC Recommendation:** 34.40  
- **Result:** Increase

- **2022 Work RVU:** 38.29
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 25.05

- **Referred to CPT**

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**RUC Meeting:** October 2009  
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**Specialty Developing Recommendation:** ACOG, AAFP  
**First Identified:** April 2008  
**2020 Medicare Utilization:** 51

- **RUC Recommendation:** 16.09  
- **Result:** Increase

- **2022 Work RVU:** 16.09
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 6.08

- **Referred to CPT**

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**First Identified:** April 2008  
**2020 Medicare Utilization:** 29

- **RUC Recommendation:** 20.26  
- **Result:** Increase

- **2022 Work RVU:** 20.06
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 8.04

- **Referred to CPT**
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| **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 | 2020 Medicare Utilization: 18 |
| RUC Recommendation: 16.66 | | | | |
| Referred to CPT | Referred to CPT Asst | Published in CPT Asst: | |
| Result: Decrease |

| **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 |
| RUC Recommendation: 22.53 | | | | |
| Referred to CPT | Referred to CPT Asst | Published in CPT Asst: | |
| Result: Increase |

<p>| <strong>60220</strong> Total thyroid lobectomy, unilateral; with or without isthmusectomy |
| Global: 090 | Issue: Total Thyroid Lobectomy | Screen: Site of Service Anomaly | Complete? Yes |
| RUC Recommendation: 12.29 | | | | |
| Referred to CPT | Referred to CPT Asst | Published in CPT Asst: | |
| Result: Maintain |</p>
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<tbody>
<tr>
<td>60225</td>
<td>Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy,</td>
<td>90</td>
<td>Total Thyroid Lobectomy</td>
<td>Site of Service Anomaly</td>
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<td>including isthmusectomy</td>
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<td>Most Recent RUC Meeting: April 2008</td>
<td>46</td>
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<td>Tab: 46, Specialty Developing Recommendation: ACS, AAO-HNS</td>
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<td>Medicare Utilization: 2020</td>
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<td>Result: Maintain</td>
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<td>Screen Recommendation:</td>
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<td>Referred to CPT Asst</td>
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<td>Published in CPT Asst</td>
<td>2022 Fac PE RVU: 10.34</td>
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</table>

| 60520  | Thymectomy, partial or total; transcervical approach (separate procedure)   | 90      | RAW Review         | CMS Request to Re-     | Yes       |
|        |                                                                              |         |                    | Review Families of    |           |
|        | Most Recent RUC Meeting: January 2013                                       | 34      |                    | Recently Reviewed CPT  |           |
|        | Tab: 34, Specialty Developing Recommendation:                               |         |                    | Codes / CMS Request -  |           |
|        | First Identified: November 2011                                             |         |                    | Final Rule for 2013    |           |
|        | Medicare Utilization: 2020                                                    | 336     |                    |                        |           |
|        | Result: Remove from Screen                                                   |         |                    |                        |           |
|        | Screen Recommendation:                                                       | 2022 Work RVU: 17.16 |            |                        |           |
|        | Referred to CPT Asst                                                         | 2022 NF PE RVU: NA |                |                        |           |
|        | Published in CPT Asst                                                        | 2022 Fac PE RVU: 10.09 |            |                        |           |

| 60521  | Thymectomy, partial or total; sternal split or transthoracic approach,       | 90      | RAW Review         | CMS Request to Re-     | Yes       |
|        | without radical mediastinal dissection (separate procedure)                  |         |                    | Review Families of    |           |
|        |                                                                              |         |                    | Recently Reviewed CPT  |           |
|        | Most Recent RUC Meeting: January 2013                                       | 34      |                    | Codes / CMS Request -  |           |
|        | Tab: 34, Specialty Developing Recommendation:                               |         |                    | Final Rule for 2013    |           |
|        | First Identified: November 2011                                             |         |                    |                        |           |
|        | Medicare Utilization: 2020                                                    | 214     |                    |                        |           |
|        | Result: Remove from Screen                                                   |         |                    |                        |           |
|        | Screen Recommendation:                                                       | 2022 Work RVU: 19.18 |            |                        |           |
|        | Referred to CPT Asst                                                         | 2022 NF PE RVU: NA |                |                        |           |
|        | Published in CPT Asst                                                        | 2022 Fac PE RVU: 9.35 |            |                        |           |
# Status Report: CMS Requests and Relativity Assessment Issues

## 60522  Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)

|-------------|-------------------|-------------------------------------------------------------------------------------------------|---------------|

**Most Recent RUC Meeting:** January 2013  
**Tab:** 34  
**Specialty Developing Recommendation:**  
**First Identified:** November 2011  
**2020 Medicare Utilization:** 91  
**Screen:** No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.  
**RUC Recommendation:** 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

<table>
<thead>
<tr>
<th>Global: 000</th>
<th>Issue: Myelography</th>
<th>Screen: Codes Reported Together 75% or More-Part2</th>
<th>Complete? Yes</th>
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**Most Recent RUC Meeting:** April 2014  
**Tab:** 17  
**Specialty Developing Recommendation:**  
**First Identified:** January 2014  
**2020 Medicare Utilization:** 166  
**Screen:** No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.  
**RUC Recommendation:** Referred to CPT  
**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)

|-------------|------------------------------------------------------------------------|-----------------------------|---------------|

**Most Recent RUC Meeting:** February 2010  
**Tab:** 13  
**Specialty Developing Recommendation:** NASS, AANS/CNS  
**First Identified:** October 2009  
**2020 Medicare Utilization:** 15,164  
**Screen:** No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.  
**RUC Recommendation:** Referred to CPT  
**Result:** Decrease  
**Referred to CPT Asst:**  
**Published in CPT Asst:**
## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
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<th>Complete?</th>
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<tbody>
<tr>
<td>61782</td>
<td>Stereotactic computer-assisted (navigational) procedure; cranial, extradural (list separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>Stereotactic Computer-Assisted Volumetric Navigational Procedures</td>
<td>CMS Fastest Growing</td>
<td>Yes</td>
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<td>RUC Recommendation: 3.18</td>
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<td>Referred to CPT Asst Published in CPT Asst:</td>
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</table>

| 61783  | Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure) | ZZZ    | Stereotactic Computer-Assisted Volumetric Navigational Procedures     | CMS Fastest Growing           | Yes       |
|        | Most Recent RUC Meeting: February 2010                                      |        | First Identified: October 2009                                        |                               |           |
|        | Tab: 13 Specialty Developing Recommendation: NASS, AANS/CNS                  |        | 2020 Medicare Utilization: 19,623                                      |                               |           |
|        | RUC Recommendation: 3.75                                                     |        | Result: Decrease                                                      |                               |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                                                                       |                               |           |

<p>| 61793  | Deleted from CPT                                                             |        | Stereotactic Radiosurgery                                             | CMS Fastest Growing, Site of Service Anomaly (99238-Only) | Yes       |
|        | Most Recent RUC Meeting: October 2008                                        |        | First Identified: September 2007                                      |                               |           |
|        | Tab: 26 Specialty Developing Recommendation: AANS                           |        | 2020 Medicare Utilization:                                             |                               |           |
|        | RUC Recommendation: Deleted from CPT                                         |        | Result: Deleted from CPT                                              |                               |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                                                                       |                               |           |</p>
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<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<td><strong>61795</strong> Deleted from CPT</td>
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<td>Specialty Developing Recommendation: NASS, AAO-HNS, AANS</td>
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<td>Global:</td>
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<td>2020 Medicare Utilization:</td>
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<td>2022 NF PE RVU:</td>
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<td>2022 Fac PE RVU:</td>
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<td>Referred to CPT Asst:</td>
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<tr>
<td><strong>61796</strong> Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion</td>
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<td>Most Recent RUC Meeting: February 2009</td>
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<td>Specialty Developing Recommendation:</td>
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<tr>
<td>First Identified: NA</td>
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<td>Global:</td>
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<td>2020 Medicare Utilization:</td>
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<tr>
<td>15.50</td>
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<tr>
<td><strong>61797</strong> Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (list separately in addition to code for primary procedure)</td>
</tr>
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<td>Most Recent RUC Meeting: February 2009</td>
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<tr>
<td>Specialty Developing Recommendation:</td>
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<td>2022 NF PE RVU:</td>
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<td>2022 Fac PE RVU:</td>
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<td>3.48</td>
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<tr>
<td><strong>61798</strong> Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion</td>
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<td>Most Recent RUC Meeting: February 2009</td>
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<tr>
<td>Specialty Developing Recommendation:</td>
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<td>2020 Medicare Utilization:</td>
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<tr>
<td>2022 NF PE RVU:</td>
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<tr>
<td>2022 Fac PE RVU:</td>
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<td>Referred to CPT</td>
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### Stereotactic Radiosurgery

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<th>Complete?</th>
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<tbody>
<tr>
<td>61799</td>
<td>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (list separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>Stereotactic Radiosurgery</td>
<td>CMS Request - 2009 Final Rule</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Most Recent RUC Meeting:** February 2009  
**Tab:** 38  
**Specialty Developing Recommendation:** First Identified: NA  
**2020 Medicare Utilization:** 786  
**2022 Work RVU:** 4.81  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 2.29

**Result:** Decrease

### Application of Stereotactic Headframe for Stereotactic Radiosurgery

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>61800</td>
<td>Application of stereotactic headframe for stereotactic radiosurgery (list separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>Stereotactic Radiosurgery</td>
<td>CMS Fastest Growing, Site of Service Anomaly (99238-Only)</td>
<td>Yes</td>
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</tbody>
</table>

**Most Recent RUC Meeting:** April 2008  
**Tab:** 16  
**Specialty Developing Recommendation:** First Identified: February 2008  
**2020 Medicare Utilization:** 4,520  
**2022 Work RVU:** 2.25  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 1.36

**Result:** Decrease

### Insertion or Replacement of Cranial Neurostimulator Pulse Generator or Receiver

<table>
<thead>
<tr>
<th>Code</th>
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<th>Complete?</th>
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<tbody>
<tr>
<td>61885</td>
<td>Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array</td>
<td>090</td>
<td>Vagal Nerve Stimulator</td>
<td>Site of Service Anomaly</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** February 2010  
**Tab:** 14  
**Specialty Developing Recommendation:** AANS/CNS  
**First Identified:** September 2007  
**2020 Medicare Utilization:** 4,795  
**2022 Work RVU:** 6.05  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 7.43

**Result:** Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>Code</th>
<th>Description</th>
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<th>Issue</th>
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<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>Medicare Utilization</th>
<th>Result</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<tbody>
<tr>
<td>62263</td>
<td>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</td>
<td>010</td>
<td>Epidural Lysis</td>
<td>Site of Service Anomaly</td>
<td>Yes</td>
<td>October 2010</td>
<td>66</td>
<td>AAPM, AANS/CNS, ASA, NASS</td>
<td>September 2007</td>
<td>205</td>
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<td>6.54</td>
<td>5.00</td>
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<tr>
<td>62270</td>
<td>Spinal puncture, lumbar, diagnostic;</td>
<td>000</td>
<td>Lumbar Puncture</td>
<td>Different Performing Specialty from Survey</td>
<td>Yes</td>
<td>January 2019</td>
<td>09</td>
<td>ACR, ASNR, SIR</td>
<td>October 2017</td>
<td>25,821</td>
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<td>1.44</td>
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<tr>
<td>62272</td>
<td>Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);</td>
<td>000</td>
<td>Lumbar Puncture</td>
<td>Different Performing Specialty from Survey</td>
<td>Yes</td>
<td>January 2019</td>
<td>09</td>
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<td>September 2018</td>
<td>3,334</td>
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</table>
# Status Report: CMS Requests and Relativity Assessment Issues

## 62281 Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic

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<tbody>
<tr>
<td>010</td>
<td>Injection of Neurolytic Agent</td>
<td>Site of Service Anomaly (99238-Only)</td>
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**Most Recent RUC Meeting:** September 2007  
**Specialty Developing Recommendation:** ASA  
**First Identified:** September 2007  
**Medicare Utilization:** 244  
**2022 Work RVU:** 2.66  
**2022 NF PE RVU:** 4.20  
**2022 Fac PE RVU:** 1.73

**RUC Recommendation:** Remove 99238  
**Referred to CPT:**  
**Referred to CPT Asst:** Published in CPT Asst: Q&A May 2010  
**Result:** PE Only

## 62284 Injection procedure for myelography and/or computed tomography, lumbar

<table>
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<tr>
<td>000</td>
<td>Myelography</td>
<td>Codes Reported Together 75% or More-Part2</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** April 2014  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** October 2012  
**Medicare Utilization:** 14,134  
**2022 Work RVU:** 1.54  
**2022 NF PE RVU:** 4.11  
**2022 Fac PE RVU:** 0.76

**RUC Recommendation:** 1.54  
**Referred to CPT:** October 2013  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Maintain

## 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

<table>
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<tr>
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<th>Issue</th>
<th>Screen</th>
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</thead>
<tbody>
<tr>
<td>090</td>
<td>Percutaneous Diskectomy</td>
<td>Site of Service Anomaly (99238-Only)</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** September 2007  
**Specialty Developing Recommendation:** ASA  
**First Identified:** September 2007  
**Medicare Utilization:** 96  
**2022 Work RVU:** 9.03  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 6.98

**RUC Recommendation:** Reduce 99238 to 0.5  
**Referred to CPT:**  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** PE Only

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<table>
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<tbody>
<tr>
<td>62290</td>
<td>Injection procedure for discography, each level; lumbar</td>
<td>000</td>
<td>Different Performing Specialty from Survey</td>
<td>April 2010</td>
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<td>ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS</td>
<td>October 2009</td>
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<td>Myelography via lumbar injection, including radiological supervision and interpretation; cervical</td>
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<td>Codes Reported Together 75% or More-Part2</td>
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<td>ACR, ASNR</td>
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<td>62303</td>
<td>Myelography via lumbar injection, including radiological supervision and interpretation; thoracic</td>
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<td>Codes Reported Together 75% or More-Part2</td>
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<td>ACR, ASNR</td>
<td>October 2012</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral</td>
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<td>Myelography</td>
<td>Codes Reported Together 75% or More-Part2</td>
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<td>2022 Fac PE RVU: 0.99</td>
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<td>62305</td>
<td>Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)</td>
<td>000</td>
<td>Myelography</td>
<td>Codes Reported Together 75% or More-Part2</td>
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<td>62310</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, or other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic</td>
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Tuesday, February 1, 2022
# 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)

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### Most Recent RUC Meeting: October 2015

### Tab: 10

### Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP

### First Identified: September 2011

### 2020 Medicare Utilization:

### Referenced to CPT: May 2015

### Referred to CPT Asst Published in CPT Asst:

### Result: Deleted from CPT

## 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

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### Most Recent RUC Meeting: October 2015

### Tab: 10

### Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP

### First Identified: January 2012

### 2020 Medicare Utilization:

### Referenced to CPT: May 2015

### Referred to CPT Asst Published in CPT Asst:

### Result: Deleted from CPT

## 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)

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### Most Recent RUC Meeting: October 2015

### Tab: 10

### Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP

### First Identified: January 2012

### 2020 Medicare Utilization:

### Referenced to CPT: May 2015

### Referred to CPT Asst Published in CPT Asst:

### Result: Deleted from CPT
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<td>62320</td>
<td>Epidural Injections</td>
<td>Final Rule for 2015</td>
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<td>1.80</td>
<td>2020</td>
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<td>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)</td>
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<td>Epidural Injections</td>
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<td>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</td>
<td>62322</td>
<td>Epidural Injections</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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)</td>
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<td>Epidural Injections</td>
<td>Final Rule for 2015</td>
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<td>October 2015</td>
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<td>May 2015</td>
<td>565,221</td>
<td>1.80</td>
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**RUC Recommendation**: 1.80

**Referred to CPT**: May 2015

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

**Result**: Decrease

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<td>62324</td>
<td>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</td>
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<td>Epidural Injections</td>
<td>Final Rule for 2015</td>
<td>Yes</td>
<td>October 2015</td>
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<td>May 2015</td>
<td>15,111</td>
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**RUC Recommendation**: 1.89

**Referred to CPT**: May 2015

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

**Result**: Decrease
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### 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)

**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  
**2020 Medicare Utilization:** 933

**2022 Work RVU:** 2.20  
**2022 NF PE RVU:** 5.26  
**2022 Fac PE RVU:** 0.85

**RUC Recommendation:** 2.20  
**Referred to CPT:** May 2015  
**Result:** Decrease

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<td>Epidural Injections</td>
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### 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

**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  
**2020 Medicare Utilization:** 3,169

**2022 Work RVU:** 1.78  
**2022 NF PE RVU:** 2.22  
**2022 Fac PE RVU:** 0.57

**RUC Recommendation:** 1.78  
**Referred to CPT:** May 2015  
**Result:** Decrease
### 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)

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**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  
**2020 Medicare Utilization:** 1,681  
**2022 Work RVU:** 1.90  
**2022 NF PE RVU:** 5.89  
**2022 Fac PE RVU:** 0.97  
**RUC Recommendation:** 1.90  
**Referred to CPT:** May 2015  
**Result:** Decrease

#### 62328 Spinal puncture, lumbar, diagnostic; with fluoroscopic or ct guidance

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<td>Different Performing Specialty from Survey</td>
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**Most Recent RUC Meeting:** January 2019  
**Tab:** 09  
**Specialty Developing Recommendation:**  
**First Identified:** September 2018  
**2020 Medicare Utilization:** 38,297  
**2022 Work RVU:** 1.73  
**2022 NF PE RVU:** 5.32  
**2022 Fac PE RVU:** 0.62  
**RUC Recommendation:** 1.95  
**Referred to CPT:** September 2018  
**Result:** Increase

#### 62329 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or ct guidance

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**Most Recent RUC Meeting:** January 2019  
**Tab:** 09  
**Specialty Developing Recommendation:**  
**First Identified:** September 2018  
**2020 Medicare Utilization:** 1,956  
**2022 Work RVU:** 2.03  
**2022 NF PE RVU:** 6.76  
**2022 Fac PE RVU:** 0.82  
**RUC Recommendation:** 2.25  
**Referred to CPT:** September 2018  
**Result:** Increase
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Implantation, revision or repositioning of tunneled intrathecal or epidural</td>
<td>010</td>
<td>Intrathecal Epidural Catheters &amp; Pumps</td>
<td>Site of Service Anomaly</td>
<td>Yes</td>
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<td>catheter, for long-term medication administration via an external pump or</td>
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<td>implantable reservoir/infusion pump; without laminectomy</td>
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| 62355  | Removal of previously implanted intrathecal or epidural catheter             | 010    | Intrathecal Epidural Catheters & Pumps     | Site of Service Anomaly                     | Yes       |       |
|        | **Most Recent RUC Meeting:** October 2010                                    |        |                                            |                                             |          |       |
|        | **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS     |        |                                            |                                             |          |       |
|        | **First Identified:** September 2007                                          |        |                                            |                                             |          |       |
|        | **2020 Medicare Utilization:** 899                                            |        |                                            |                                             |          |       |
|        | **2022 Work RVU:** 3.55                                                       |        |                                            |                                             |          |       |
|        | **2022 NF PE RVU:** NA                                                        |        |                                            |                                             |          |       |
|        | **2022 Fac PE RVU:** 3.75                                                     |        |                                            |                                             |          |       |
|        | **Result:** Decrease                                                          |        |                                            |                                             |          |       |
|        | **RUC Recommendation:** 4.35                                                  |        |                                            |                                             |          |       |
|        | **Referred to CPT**                                                           |        |                                            |                                             |          |       |
|        | **Referred to CPT Asst**                                                      |        |                                            |                                             |          |       |
|        | **Published in CPT Asst:**                                                    |        |                                            |                                             |          |       |

| 62360  | Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir | 010 | Intrathecal Epidural Catheters & Pumps | Site of Service Anomaly | Yes |       |
|        | **Most Recent RUC Meeting:** October 2010                                    |        |                                            |                                             |          |       |
|        | **Specialty Developing Recommendation:** AAPM, ASA, NASS, AAPM, AANS/CNS      |        |                                            |                                             |          |       |
|        | **First Identified:** April 2008                                              |        |                                            |                                             |          |       |
|        | **2020 Medicare Utilization:** 182                                             |        |                                            |                                             |          |       |
|        | **2022 Work RVU:** 4.33                                                       |        |                                            |                                             |          |       |
|        | **2022 NF PE RVU:** NA                                                         |        |                                            |                                             |          |       |
|        | **2022 Fac PE RVU:** 4.23                                                     |        |                                            |                                             |          |       |
|        | **Result:** Decrease                                                          |        |                                            |                                             |          |       |
|        | **RUC Recommendation:** 4.33                                                  |        |                                            |                                             |          |       |
|        | **Referred to CPT**                                                           |        |                                            |                                             |          |       |
|        | **Referred to CPT Asst**                                                      |        |                                            |                                             |          |       |
|        | **Published in CPT Asst:**                                                    |        |                                            |                                             |          |       |

| 62361  | Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump | 010 | Intrathecal Epidural Catheters & Pumps | Site of Service Anomaly | Yes |       |
|        | **Most Recent RUC Meeting:** October 2010                                    |        |                                            |                                             |          |       |
|        | **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS      |        |                                            |                                             |          |       |
|        | **First Identified:** April 2008                                              |        |                                            |                                             |          |       |
|        | **2020 Medicare Utilization:** 16                                              |        |                                            |                                             |          |       |
|        | **2022 Work RVU:** 5.00                                                       |        |                                            |                                             |          |       |
|        | **2022 NF PE RVU:** NA                                                         |        |                                            |                                             |          |       |
|        | **2022 Fac PE RVU:** 6.00                                                     |        |                                            |                                             |          |       |
|        | **Result:** Decrease                                                          |        |                                            |                                             |          |       |
|        | **RUC Recommendation:** 5.65                                                  |        |                                            |                                             |          |       |
|        | **Referred to CPT**                                                           |        |                                            |                                             |          |       |
|        | **Referred to CPT Asst**                                                      |        |                                            |                                             |          |       |
|        | **Published in CPT Asst:**                                                    |        |                                            |                                             |          |       |

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## Status Report: CMS Requests and Relativity Assessment Issues

### 62362
**Description:** Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming

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<tr>
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### 62365
**Description:** Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

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### 62367
**Description:** 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

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<td>Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming</td>
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<td>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)</td>
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<td>Issue</td>
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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)

**Referred to CPT Assst:** □ Published in CPT Assst:
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Lumbar Laminotomy with Decompression</td>
<td>Site of Service Anomaly - 2018</td>
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#### Most Recent RUC Meeting: January 2022

#### Medicare Utilization:

- **First Identified:** January 2022
- **Medicare Utilization:** 1,043

#### RUC Recommendation: 15.95

- **Status:** Referred to CPT
- **Published in CPT Asst:** Yes
- **Result:** Decrease

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#### Most Recent RUC Meeting: January 2022

#### Medicare Utilization:

- **First Identified:** January 2014
- **Medicare Utilization:** 22,190

#### RUC Recommendation: 13.18

- **Status:** Referred to CPT
- **Published in CPT Asst:** Yes
- **Result:** Maintain

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#### Most Recent RUC Meeting: January 2022

#### Medicare Utilization:

- **First Identified:** January 2022
- **Medicare Utilization:** 5,431

#### RUC Recommendation: 4.00

- **Status:** Referred to CPT
- **Published in CPT Asst:** Yes
- **Result:** Increase

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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>2020 NF PE RVU</th>
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<td>63042</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar</td>
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### 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

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**Most Recent RUC Meeting:** January 2013  
**Tab:** 24  
**Specialty Developing Recommendation:** NASS, AANS  
**First Identified:** September 2011  
**Medicare Utilization:** 83,353

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**Result:** Maintain

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### 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 vertebral segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)

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**Most Recent RUC Meeting:** January 2013  
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**Specialty Developing Recommendation:** NASS, AANS  
**First Identified:** January 2012  
**Medicare Utilization:** 108,554

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**Result:** Maintain

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### 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)

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**Most Recent RUC Meeting:** October 2015  
**Tab:** 21  
**Specialty Developing Recommendation:** NASS, AANS  
**First Identified:** October 2008  
**Medicare Utilization:** 4,943

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**Result:** Maintain

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# Status Report: CMS Requests and Relativity Assessment Issues

## 63075  
**Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

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**Most Recent RUC Meeting:** February 2010  
**Tab:** 5  
**Specialty Developing Recommendation:** NASS, AANS/CNS  
**First Identified:** February 2008  
**Medicare Utilization:** 346  
**2022 Work RVU:** 19.60  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 14.70

**RUC Recommendation:** 19.60  
**Referred to CPT:** October 2009  
**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)**

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**Most Recent RUC Meeting:** February 2010  
**Tab:** 5  
**Specialty Developing Recommendation:** NASS, AANS/CNS  
**First Identified:** February 2008  
**Medicare Utilization:** 274  
**2022 Work RVU:** 4.04  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 1.98

**RUC Recommendation:** 4.04  
**Referred to CPT:** October 2009  
**Published in CPT Asst:**

## 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**

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<td>Vertebral Corpectomy with Arthrodesis</td>
<td>Codes Reported Together 75% or More-Part3</td>
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**Most Recent RUC Meeting:** January 2017  
**Tab:** 30  
**Specialty Developing Recommendation:** AAOS, AANS  
**First Identified:** January 2015  
**Medicare Utilization:** 738  
**2022 Work RVU:** 30.93  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 18.90

**RUC Recommendation:** Review action plan and additional data  
**Referred to CPT:** September 2016  
**Published in CPT Asst:**

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (list separately in addition to code for primary procedure)</td>
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<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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| 63660  | Deleted from CPT                                                             |        |                           |                         | Yes       |
|        | Most Recent RUC Meeting: April 2009                                          |        |                           |                         |           |
|        | Tab: 17 Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS |        |                           |                         |           |
|        | First Identified: September 2007                                             |        |                           |                         |           |
|        | Issue: 2020 Medicare Utilization:                                             |        |                           |                         |           |
|        | Screen: Site of Service Anomaly / CMS Fastest Growing                        |        |                           |                         |           |
|        | 2022 Work RVU:                                                               |        |                           |                         |           |
|        | 2022 NF PE RVU:                                                              |        |                           |                         |           |
|        | 2022 Fac PE RVU:                                                             |        |                           |                         |           |
|        | RUC Recommendation: Deleted from CPT                                         |        |                           |                         |           |
|        | Referral to CPT                                                               |        |                           |                         |           |
|        | Published in CPT Asst:                                                        |        |                           |                         |           |
|        | Result: Deleted from CPT                                                      |        |                           |                         |           |

| 63661  | Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed | 010    | Neurostimulator (Spinal)   | Site of Service Anomaly / CMS Fastest Growing | Yes       |
|        | Most Recent RUC Meeting: April 2009                                          |        |                           |                         |           |
|        | Tab: 17 Specialty Developing Recommendation: ISIS, NASS, AANS, AAPM          |        |                           |                         |           |
|        | First Identified: April 2008                                                 |        |                           |                         |           |
|        | Issue: 2020 Medicare Utilization: 3,183                                       |        |                           |                         |           |
|        | Screen: 2022 Work RVU: 5.08                                                    |        |                           |                         |           |
|        | 2022 NF PE RVU: 14.57                                                         |        |                           |                         |           |
|        | 2022 Fac PE RVU: 3.66                                                         |        |                           |                         |           |
|        | RUC Recommendation: 5.03                                                       |        |                           |                         |           |
|        | Referral to CPT                                                               |        |                           |                         |           |
|        | Published in CPT Asst:                                                        |        |                           |                         |           |
|        | Result: Decrease                                                              |        |                           |                         |           |

| 63662  | Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed | 090    | Neurostimulator (Spinal)   | Site of Service Anomaly / CMS Fastest Growing | Yes       |
|        | Most Recent RUC Meeting: April 2009                                          |        |                           |                         |           |
|        | Tab: 17 Specialty Developing Recommendation: ISIS, NASS, AANS, AAPM          |        |                           |                         |           |
|        | First Identified: April 2008                                                 |        |                           |                         |           |
|        | Issue: 2020 Medicare Utilization: 2,049                                       |        |                           |                         |           |
|        | Screen: 2022 Work RVU: 11.00                                                   |        |                           |                         |           |
|        | 2022 NF PE RVU: NA                                                            |        |                           |                         |           |
|        | 2022 Fac PE RVU: 10.58                                                        |        |                           |                         |           |
|        | RUC Recommendation: 10.87                                                      |        |                           |                         |           |
|        | Referral to CPT                                                               |        |                           |                         |           |
|        | Published in CPT Asst:                                                        |        |                           |                         |           |
|        | Result: Decrease                                                              |        |                           |                         |           |
# Status Report: CMS Requests and Relativity Assessment Issues

## 63663
Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

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| Most Recent RUC Meeting: | April 2009 |
| Tab: | 17 |
| Specialty Developing Recommendation: | ISIS, NASS, AANS/CNS, ASA, AAPM |
| First Identified: | April 2008 |
| RUC Recommendation: | 70 |
| Referred to CPT | |
| Referred to CPT Asst | |
| Published in CPT Asst: | |
| Result: | Increase |

| Medicare Utilization: | 1,472 |
| 2020 | 2022 Work RVU: | 7.75 |
| 2022 NF PE RVU: | 18.26 |
| 2022 Fac PE RVU: | 4.45 |

## 63664
Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

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| Most Recent RUC Meeting: | April 2009 |
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| Specialty Developing Recommendation: | ISIS, NASS, AANS/CNS, ASA, AAPM |
| First Identified: | April 2008 |
| RUC Recommendation: | 11.39 |
| Referred to CPT | |
| Referred to CPT Asst | |
| Published in CPT Asst: | |
| Result: | Decrease |

| Medicare Utilization: | 580 |
| 2020 | 2022 Work RVU: | 11.52 |
| 2022 NF PE RVU: | NA |
| 2022 Fac PE RVU: | 10.88 |

## 63685
Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

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| Most Recent RUC Meeting: | January 2021 |
| Tab: | 29 |
| Specialty Developing Recommendation: | AAPM, AANS/CNS, ASA, ISIS, NASS |
| First Identified: | September 2007 |
| RUC Recommendation: | Review action plan in 2 years after CPT article published. 6.05 |
| Referred to CPT | |
| Referred to CPT Asst | |
| Published in CPT Asst: | |
| Result: | Decrease |

| Medicare Utilization: | 24,783 |
| 2020 | 2022 Work RVU: | 5.19 |
| 2022 NF PE RVU: | NA |
| 2022 Fac PE RVU: | 4.43 |
## Status Report: CMS Requests and Relativity Assessment Issues

### Revision or removal of implanted spinal neurostimulator pulse generator or receiver

**63688**

**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  
**2020 Medicare Utilization:** 6,983

**RUC Recommendation:** 5.25

- Referred to CPT
- Published in CPT Asst: 

**2022 Work RVU:** 5.30  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 4.57

**Result:** Decrease

### Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)

**64400**

**Global:** 000  
**Issue:** Somatic Nerve Injections  
**Screen:** Added as part of family  
**Complete?** Yes

**Most Recent RUC Meeting:** October 2021  
**Tab:** 05  
**Specialty Developing Recommendation:** AAN, AAPM&R, AAPM, NANS, SIS  
**First Identified:** October 2021  
**2020 Medicare Utilization:** 34,519

**RUC Recommendation:** 1.00

- Referred to CPT
- Published in CPT Asst: 

**2022 Work RVU:** 0.75  
**2022 NF PE RVU:** 2.44  
**2022 Fac PE RVU:** 0.54

**Result:** Decrease

### Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve

**64405**

**Global:** 000  
**Issue:** Somatic Nerve Injections  
**Screen:** CMS 000-Day Global Typically Reported with an E/M  
**Complete?** Yes

**Most Recent RUC Meeting:** October 2021  
**Tab:** 05  
**Specialty Developing Recommendation:** AAN, AAPM, AAPM&R, NANS, SIS  
**First Identified:** July 2016  
**2020 Medicare Utilization:** 116,809

**RUC Recommendation:** 0.94

- Referred to CPT
- Published in CPT Asst: 

**2022 Work RVU:** 0.94  
**2022 NF PE RVU:** 1.09  
**2022 Fac PE RVU:** 0.41

**Result:** Maintain

### Injection(s), anesthetic agent(s) and/or steroid; vagus nerve

**64408**

**Global:** 000  
**Issue:** Somatic Nerve Injections  
**Screen:** Added as part of family  
**Complete?** Yes

**Most Recent RUC Meeting:** October 2021  
**Tab:** 05  
**Specialty Developing Recommendation:** AAPM, NANS, SIS  
**First Identified:** October 2021  
**2020 Medicare Utilization:** 873

**RUC Recommendation:** 0.90

- Referred to CPT
- Published in CPT Asst: 

**2022 Work RVU:** 0.75  
**2022 NF PE RVU:** 1.58  
**2022 Fac PE RVU:** 0.46

**Result:** Decrease
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<td>64412</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve</th>
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<td>64447</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve</td>
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<td>2022 Fac PE RVU: 0.35</td>
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### Table 1: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)

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<th>Case Number</th>
<th>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)</th>
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<th>Issue: Somatic Nerve Injections</th>
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<td>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)</td>
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### Table 2: Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

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<th>Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)</th>
<th>Global: 000</th>
<th>Issue: Somatic Nerve Injections</th>
<th>Screen: Site of Service Anomaly</th>
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<tr>
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<td>Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 64450 - Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

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<th>Screen: Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / High Volume Growth4</th>
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### 64451 - Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

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<td>Specialty Developing Recommendation: AAPM, AAPM&amp;R, NANS, SIS</td>
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### 64454 - Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed

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<td><strong>64455</strong> Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, morton's neuroma)</td>
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<td><strong>Issue:</strong> Somatic Nerve Injections</td>
<td><strong>Screen:</strong> High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M</td>
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### Paravertebral Block (pVB) (paraspinous block), Thoracic

| **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 |
|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| **RUC Meeting:** April 2015 | Tab: 10 | Specialty Developing Recommendation: ASA | First Identified: April 2015 | 2020 Medicare Utilization: 5,928 | 2022 Work RVU: 1.75 | 2022 NF PE RVU: 2.14 | 2022 Fac PE RVU: 0.38 |
| RUC Recommendation: CPT Assistant article published Jan 2016 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: Jan 2016 | Result: Not Part of RAW |

| **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 |
|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| **RUC Meeting:** April 2015 | Tab: 10 | Specialty Developing Recommendation: ASA | First Identified: April 2015 | 2020 Medicare Utilization: 1,686 | 2022 Work RVU: 1.10 | 2022 NF PE RVU: 0.97 | 2022 Fac PE RVU: 0.24 |
| RUC Recommendation: CPT Assistant article published Jan 2016 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: Jan 2016 | Result: Not Part of RAW |

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Tuesday, February 1, 2022
## 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

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### 64470 Deleted from CPT

**Global:** |  
**Issue:** Injection Anesthetic Agent  
**Screen:** High Volume Growth1  
**Complete?** Yes

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**Screen:** High Volume Growth1  
**Complete?** Yes

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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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| 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 |

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| 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 |

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| 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 |

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**Most Recent RUC Meeting:** October 2009  
**Specialty Developing Recommendations:** AAPM, ISIS, ASA, NASS, AAPMR  
**First Identified:** October 2008  
**Medicare Utilization:** 358,506  
**2022 Work RVU:** 1.00  
**2022 NF PE RVU:** 2.27  
**2022 Fac PE RVU:** 0.41  

**RUC Recommendation:** 1.00  
**Referred to CPT:** June 2009  
**Referred to CPT Asst:**  
**Published in CPT Asst:**

**Result:** Decrease

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<td>Facet Joint Injections</td>
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**Most Recent RUC Meeting:** April 2009  
**Specialty Developing Recommendations:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS  
**First Identified:** April 2009  
**Medicare Utilization:** 219,560  
**2022 Work RVU:** 1.82  
**2022 NF PE RVU:** 3.68  
**2022 Fac PE RVU:** 1.08  

**RUC Recommendation:** 1.82  
**Referred to CPT:**  
**Referred to CPT Asst:**  
**Published in CPT Asst:**

**Result:** Decrease

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**Most Recent RUC Meeting:** April 2009  
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**First Identified:** April 2009  
**Medicare Utilization:** 195,781  
**2022 Work RVU:** 1.16  
**2022 NF PE RVU:** 1.60  
**2022 Fac PE RVU:** 0.47  

**RUC Recommendation:** 1.16  
**Referred to CPT:**  
**Referred to CPT Asst:**  
**Published in CPT Asst:**

**Result:** Decrease
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### 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)**

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- **Result:** Decrease
- **Referred to CPT**
- **Published in CPT Asst:**

#### 64510
**Injection, anesthetic agent; stellate ganglion (cervical sympathetic)**

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- **Result:** PE Only
- **Referred to CPT**
- **Published in CPT Asst:**

#### 64520
**Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)**

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<td>2022 Fac PE RVU: 1.00</td>
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- **Result:** PE Only
- **Referred to CPT**
- **Published in CPT Asst:**
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
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<td>64550</td>
<td>Application of surface (transcutaneous) neurostimulator (eg, TENS unit)</td>
<td>Percutaneous Neurostimulator Placement</td>
<td>Jan 2017</td>
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<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrode array; cranial nerve</td>
<td>Percutaneous Neurostimulator Placement</td>
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<td>64555</td>
<td>Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>RVU 2022 NF PE</th>
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<td>64561</td>
<td>Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed</td>
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<td>Percutaneous NeurostimulatorPlacement</td>
<td>CMS Fastest Growing / High Level E/M in Global Period / PE Units Screen</td>
<td>Yes</td>
<td>5.44. 99214 visit appropriate. Remove from screen.</td>
<td>October 2020</td>
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<td>14,187</td>
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<td>64565</td>
<td>Percutaneous implantation of neurostimulator electrode array; neuromuscular</td>
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<td>Final Rule for 2015</td>
<td>Yes</td>
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<td>64566</td>
<td>Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming</td>
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<td>Posterior Tibial Neurostimulation</td>
<td>CMS Request - Final Rule for 2014 / High Volume Growth5</td>
<td>Yes</td>
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<td>ACOG, AUA</td>
<td>July 2013</td>
<td>144,067</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td><strong>64568</strong></td>
<td>Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
<td>090</td>
<td>Vagus Nerve Stimulator</td>
<td>Site of Service Anomaly</td>
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<td><strong>64573</strong></td>
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<td><strong>64581</strong></td>
<td>Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)</td>
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<td>Urological Procedures</td>
<td>Site of Service Anomaly / High Level E/M in Global Period</td>
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### 64568
- **Most Recent RUC Meeting**: February 2010
- **Tab**: 14
- **Specialty Developing Recommendation**: AANS/CNS
- **First Identified**: February 2009
- **2020 Medicare Utilization**: 1,108

#### RUC Recommendation:
- **Global**: 11.19
- **Screen**: First Identified: February 2009
- **Result**: Referred to CPT
- **Referred to CPT Asst**: Published in CPT Asst: October 2009
- **Complete?**: Yes

### 64573
- **Most Recent RUC Meeting**: February 2009
- **Tab**: 28
- **Specialty Developing Recommendation**: AANS/CNS
- **First Identified**: September 2007

#### RUC Recommendation:
- **Global**: Deleted from CPT
- **Screen**: Published in CPT Asst: October 2009
- **Complete?**: Yes

### 64581
- **Most Recent RUC Meeting**: January 2016
- **Tab**: 54
- **Specialty Developing Recommendation**: AUA
- **First Identified**: September 2007

#### RUC Recommendation:
- **Global**: 12.20. 99214 visit appropriate. Remove from screen.
- **Screen**: Published in CPT Asst: October 2009
- **Complete?**: Yes
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
<td>010</td>
<td>RAW</td>
<td>Harvard-Valued Annual Allowed Charges Greater than $10 million / Different Performing Specialty from Survey</td>
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**Most Recent RUC Meeting:** January 2018  
**Tab:** 31  
**Specialty Developing Recommendation:** ACOG, AUA  
**First Identified:** October 2012  
**Medicare Utilization:** 11,819  
**Result:** Remove from screen

### 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  
**Medicare Utilization:** 137,679  
**Result:** Maintain

### 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  
**Medicare Utilization:**  
**Result:** Deleted from CPT
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<td>Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or</td>
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<td>Destruction by</td>
<td>High Volume Growth1, Harvard</td>
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<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, single facet joint</td>
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<td>Destruction by Neurolytic Agent</td>
<td>Work Neutrality Review</td>
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<td>64634</td>
<td>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)</td>
<td>ZZZ</td>
<td>Destruction by Neurolytic Agent</td>
<td>Work Neutrality Review</td>
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<td>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)</td>
<td>ZZZ</td>
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<td>Destruction by neurolytic agent; other peripheral nerve or branch</td>
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<td>Injection Treatment of Nerve</td>
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<td>Neuroplasty, major peripheral nerve, arm or leg, open; other than specified</td>
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<td>Neuroplasty – Leg or Arm</td>
<td>Site of Service Anomaly</td>
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<td>Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve</td>
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<td>Suture of digital nerve, hand or foot; 1 nerve</td>
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<td>Neurorrhaphy – Finger</td>
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<td>Enucleation of eye; with implant, muscles attached to implant</td>
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<td>Ophthalmologic Procedures</td>
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<td>65205</td>
<td>Removal of foreign body, external eye; conjunctival superficial</td>
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<td>Removal of Foreign Body - Eye</td>
<td>CMS 000-Day Global Typically Reported with an E/M</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

## 65210 Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating

<table>
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<tr>
<th>Global:</th>
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<th>Screen: CMS 000-Day Global Typically Reported with an E/M</th>
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<td>April 2017</td>
<td>Specialty Developing Recommendation: AAO, AOA</td>
<td>First Identified: July 2016</td>
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## 65222 Removal of foreign body, external eye; corneal, with slit lamp

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## 65285 Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue

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### Status Report: CMS Requests and Relativity Assessment Issues

**65780** Ocular surface reconstruction; amniotic membrane transplantation, multiple layers

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<td>Ocular Reconstruction Transplant</td>
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- **Most Recent RUC Meeting:** April 2015
- **Tab:** 31
- **Specialty Developing Recommendation:** AAO

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<td>1,462</td>
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- **RUC Recommendation:** 8.80
- **Result:** Decrease
- **Published in CPT Asst:** Jun 2009

**65800** Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous

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- **Most Recent RUC Meeting:** April 2012
- **Tab:** 21
- **Specialty Developing Recommendation:** AAO

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- **RUC Recommendation:** 1.53
- **Result:** Decrease
- **Published in CPT Asst:**

**65805** Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous

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- **Most Recent RUC Meeting:** April 2012
- **Tab:** 21
- **Specialty Developing Recommendation:** AAO

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- **RUC Recommendation:** Deleted from CPT
- **Result:** Deleted from CPT
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>66172</td>
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<td>Glaucoma Surgery</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Transluminal dilation of aqueous outflow canal; with retention of device or stent</td>
<td>090</td>
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**Note:**
- Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits
- Complete?: Yes

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**References:**
- Medicare Utilization: Decrease
- Harvard-Valued Annual Allowed Charges Greater than $10 million
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach</td>
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<td>Aqueous Shunt</td>
<td>Yes</td>
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<td>5,855</td>
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<td>66184</td>
<td>Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft</td>
<td>090</td>
<td>Aqueous Shunt</td>
<td>Yes</td>
<td>January 2014</td>
<td>12</td>
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<td>intraocular lens, or primary posterior capsulorrhexis) or performed</td>
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<td>without endoscopic cyclophotocoagulation</td>
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<td><strong>2022 Work RVU:</strong> 7.35</td>
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<td><strong>2022 Fac PE RVU:</strong> 7.83</td>
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<td><strong>Result:</strong> Decrease</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Global</th>
<th>Screen</th>
<th>Complete?</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td>Cataract Removal with Drainage Device Insertion</td>
<td>Codes Reported Together 75% or More-Part4</td>
<td>Yes</td>
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<tr>
<td>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</td>
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<tr>
<td>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 insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more</td>
<td>Cataract Removal with Drainage Device Insertion</td>
<td>High Volume Category III Codes</td>
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</table>

**66987**

**Most Recent RUC Meeting:** January 2021  
**Tab:** 16  
**Specialty Developing Recommendation:** AAO  
**First Identified:** January 2019  
**2020 Medicare Utilization:** 733  
**2022 Work RVU:** 0.00  
**2022 NF PE RVU:** 0.00  
**2022 Fac PE RVU:** 0.00  
**Result:** Decrease

**66988**

**Most Recent RUC Meeting:** January 2019  
**Tab:** 11  
**Specialty Developing Recommendation:**  
**First Identified:** January 2019  
**2020 Medicare Utilization:** 3,826  
**2022 Work RVU:** 0.00  
**2022 NF PE RVU:** 0.00  
**2022 Fac PE RVU:** 0.00  
**Result:** Decrease

**66989**

**Most Recent RUC Meeting:** January 2021  
**Tab:** 16  
**Specialty Developing Recommendation:** AAO  
**First Identified:** January 2021  
**2020 Medicare Utilization:**  
**2022 Work RVU:** 12.13  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 11.69  
**Result:** Maintain

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 insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
### Status Report: CMS Requests and Relativity Assessment Issues

**66991** Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

<table>
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<tr>
<th>Global: 090</th>
<th>Issue: Cataract Removal with Drainage Device Insertion</th>
<th>Screen: High Volume Category III Codes</th>
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<tbody>
<tr>
<td><strong>Most Recent</strong> RUC Meeting: <strong>January 2021</strong></td>
<td><strong>Tab: 16</strong> Specialty Developing Recommendation: AAO</td>
<td><strong>First Identified:</strong> January 2021</td>
<td><strong>2022 Work RVU:</strong> 9.23</td>
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<td><strong>RUC Recommendation:</strong> 9.23</td>
<td><strong>2022 NF PE RVU:</strong> NA</td>
<td><strong>2022 Fac PE RVU:</strong> 9.84</td>
<td><strong>Result:</strong> Maintain</td>
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<td>Referred to CPT</td>
<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
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</table>

**67028** Intravitreal injection of a pharmacologic agent (separate procedure)

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<thead>
<tr>
<th>Global: 000</th>
<th>Issue: Treatment of Retinal Lesion</th>
<th>Screen: High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3</th>
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<td><strong>Most Recent</strong> RUC Meeting: <strong>April 2019</strong></td>
<td><strong>Tab: 14</strong> Specialty Developing Recommendation: AAO, ASRS</td>
<td><strong>First Identified:</strong> February 2008</td>
<td><strong>2022 Work RVU:</strong> 1.44</td>
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<td><strong>RUC Recommendation:</strong> 1.44</td>
<td><strong>2022 NF PE RVU:</strong> 1.75</td>
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**67036** Vitrectomy, mechanical, pars plana approach;

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<tr>
<th>Global: 090</th>
<th>Issue: Vitrectomy</th>
<th>Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td><strong>Most Recent</strong> RUC Meeting: <strong>October 2013</strong></td>
<td><strong>Tab: 11</strong> Specialty Developing Recommendation: AAO</td>
<td><strong>First Identified:</strong> October 2012</td>
<td><strong>2022 Work RVU:</strong> 12.13</td>
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<tr>
<td><strong>RUC Recommendation:</strong> 12.13</td>
<td><strong>2022 NF PE RVU:</strong> NA</td>
<td><strong>2022 Fac PE RVU:</strong> 12.85</td>
<td><strong>Result:</strong> Decrease</td>
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<td>Identified: September 2007, 2020 Medicare Utilization:</td>
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<td>Result: Deleted from CPT</td>
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<tr>
<td>67039</td>
<td>Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation</td>
<td>090</td>
<td>Vitrectomy</td>
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<tr>
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<td>Most Recent RUC Meeting: October 2013, Specialty Developing Recommendation: AAO</td>
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<td>First Identified: September 2007, 2020 Medicare Utilization:</td>
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<td>Published in CPT Asst:</td>
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<td>Result: Decrease</td>
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<tr>
<td>67040</td>
<td>Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation</td>
<td>090</td>
<td>Vitrectomy</td>
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<td>Most Recent RUC Meeting: October 2013, Specialty Developing Recommendation: AAO</td>
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<td>Published in CPT Asst:</td>
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<td></td>
<td>Result: Decrease</td>
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<td>Status Report: CMS Requests and Relativity Assessment Issues</td>
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<tr>
<td><strong>67041</strong> Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)</td>
<td>Global: 900</td>
<td>Issue: Vitrectomy</td>
<td>Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million</td>
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<td>RUC Recommendation: 16.33</td>
<td>Referred to CPT</td>
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<tr>
<td>Result: Decrease</td>
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| **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: 900 | Issue: Vitrectomy | Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million | Complete? Yes |
| RUC Recommendation: 16.33 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: |
| Result: Decrease |

<p>| <strong>67043</strong> 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: 900 | Issue: Vitrectomy | Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million | Complete? Yes |
| RUC Recommendation: 17.40 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: |
| Result: Decrease |</p>
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<th>Procedure Description</th>
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<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>67101 Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy</td>
<td>010</td>
<td>Retinal Detachment Repair</td>
<td>090-Day Global Post-Operative Visits</td>
<td>Yes</td>
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<tr>
<td>RUC Recommendation: 3.50</td>
<td>Referred to CPT May 2015</td>
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<td>Result: Decrease</td>
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<tr>
<td>67105 Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation</td>
<td>010</td>
<td>Retinal Detachment Repair</td>
<td>090-Day Global Post-Operative Visits</td>
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<td>RUC Recommendation: 3.84</td>
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<tr>
<td>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</td>
<td>090</td>
<td>Retinal Detachment Repair</td>
<td>Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits</td>
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<tr>
<td>RUC Recommendation: 16.00. Reduce 99238 to 0.5</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td><strong>67108</strong></td>
<td>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</td>
<td>090</td>
<td>Retinal Detachment Repair</td>
<td>Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits</td>
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<td>RUC Recommendation: 17.13</td>
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<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
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| **67110** | Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy) | 090    | Retinal Detachment Repair | Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits | Yes       |
| 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 | 090-Day Global Post-Operative Visits | Retinal Detachment Repair | Site of Service Anomaly (99238-Only) | Yes       |
| Most Recent RUC Meeting: April 2015 | Tab: 12 | Specialty Developing Recommendation: AAO | First Identified: April 2014 | 2020 Medicare Utilization: |          |
| 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

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<th>CMS Request Number</th>
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<tr>
<td>67113</td>
<td>Repair of complex retinal detachment (e.g., 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 photoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens</td>
<td>090</td>
<td>Retinal Detachment Repair</td>
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<td>67141</td>
<td>Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage; cryotherapy, diathermy</td>
<td>090</td>
<td>Retinal Detachment Prophylaxis</td>
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<tr>
<td>67145</td>
<td>Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage; photoagulation</td>
<td>090</td>
<td>Retinal Detachment Prophylaxis</td>
<td>27,120</td>
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**Notes:**
- Medicare Utilization: 11,077
- Complete?: Yes
- RUC Recommendation: 19.00
- Published in CPT Asst: October 2014
- Result: Decrease

- Medicare Utilization: 1,048
- Complete?: Yes
- RUC Recommendation: 2.53
- Published in CPT Asst: May 2020
- Result: Decrease

- Medicare Utilization: 27,120
- Complete?: Yes
- RUC Recommendation: 2.53
- Published in CPT Asst: May 2020
- Result: Decrease
Status Report: CMS Requests and Relativity Assessment Issues

67210 Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation

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<th>Complete?</th>
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<td>090</td>
<td>Treatment of Retinal Lesion or Choroid</td>
<td>High IWPUT</td>
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Most Recent RUC Meeting: October 2010  
Tab: 13  
Specialty Developing Recommendation: AAO  
First Identified: February 2008  
RUC Recommendation: 6.36  
2022 Work RVU: 6.36  
2022 NF PE RVU: 8.13  
2022 Fac PE RVU: 7.55  
Result: Decrease

67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

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<th>Issue:</th>
<th>Screen:</th>
<th>Complete?</th>
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<tr>
<td>090</td>
<td>Treatment of Retinal Lesion or Choroid</td>
<td>High IWPUT</td>
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Most Recent RUC Meeting: October 2010  
Tab: 13  
Specialty Developing Recommendation: AAO  
First Identified: February 2008  
RUC Recommendation: 6.36  
2022 Work RVU: 6.36  
2022 NF PE RVU: 8.58  
2022 Fac PE RVU: 7.55  
Result: Decrease

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)

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<tr>
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<th>Issue:</th>
<th>Screen:</th>
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<tr>
<td>ZZZ</td>
<td>Photodynamic Therapy of the Eye</td>
<td>New Technology</td>
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Most Recent RUC Meeting: February 2008  
Tab: P  
Specialty Developing Recommendation: AAO  
First Identified: September 2007  
RUC Recommendation: 0.47  
2022 Work RVU: 0.47  
2022 NF PE RVU: 0.34  
2022 Fac PE RVU: 0.29  
Result: Maintain

67228 Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation

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<tr>
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<tr>
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Most Recent RUC Meeting: October 2009  
Tab: 40  
Specialty Developing Recommendation: AAO  
First Identified: February 2008  
RUC Recommendation: Remove from screen  
2022 Work RVU: 4.39  
2022 NF PE RVU: 5.14  
2022 Fac PE RVU: 4.04  
Result: Remove from Screen
### Status Report: CMS Requests and Relativity Assessment Issues

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

**Global:** 090  **Issue:** Aqueous Shunt  **Complete?** Yes

<table>
<thead>
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<th>Tab: 12</th>
<th>Specialty Developing Recommendation:</th>
<th>AAO</th>
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**Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million

**Result:**

- **2022 Work RVU:** 8.38
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 10.92

---

#### 67311  Strabismus surgery, recession or resection procedure; 1 horizontal muscle

**Global:** 090  **Issue:** Strabismus Surgery  **Complete?** Yes

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<th>Tab: 18</th>
<th>Specialty Developing Recommendation:</th>
<th>AAO, AAP</th>
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</thead>
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**Screen:** ZZZ Global Post-Operative Visits

**Result:** Decrease

- **2022 Work RVU:** 5.93
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 7.61

---

#### 67312  Strabismus surgery, recession or resection procedure; 2 horizontal muscles

**Global:** 090  **Issue:** Strabismus Surgery  **Complete?** Yes

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**Screen:** ZZZ Global Post-Operative Visits

**Result:** Decrease

- **2022 Work RVU:** 9.50
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 9.01
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>67320</td>
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<td>67331</td>
<td>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)</td>
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</table>

| 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) | ZZZ    | Strabismus Surgery     | ZZZ Global Post-Operative Visits | Yes       |
|      | RUC Recommendation: 3.50 | Referral to CPT | Refer to CPT Asst Published in CPT Asst: | Result: Decrease | 2022 NF PE RVU: NA | 2022 Fac PE RVU: 3.86 |

| 67334| Strabismus surgery by posterior fixation suture technique, with or without muscle recession (list separately in addition to code for primary procedure) | ZZZ    | Strabismus Surgery     | ZZZ Global Post-Operative Visits | Yes       |
|      | RUC Recommendation: 2.06 | Referral to CPT | Refer to CPT Asst Published in CPT Asst: | Result: Decrease | 2022 NF PE RVU: NA | 2022 Fac PE RVU: 4.69 |
# Status Report: CMS Requests and Relativity Assessment Issues

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<td>67335</td>
<td>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)</td>
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<td>67500</td>
<td>Retrobulbar injection; medication (separate procedure, does not include supply of medication)</td>
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**Table:**

- **Global:** ZZZ
- **Issue:** Strabismus Surgery
- **Screen:** ZZZ Global Post-Operative Visits
- **Complete?** Yes

- **RUC Meeting:** October 2020
- **Specialty Developing Recommendation:** AAO, AAP
- **First Identified:** October 2019
- **2020 Medicare Utilization:**
  - Work RVU: 3.23
  - NF PE RVU: NA
  - Fac PE RVU: 1.96
- **Result:** Increase

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

- **RUC Meeting:** October 2017
- **Specialty Developing Recommendation:** AAO, ASRS
- **First Identified:** October 2017
- **2020 Medicare Utilization:**
  - Work RVU: 1.18
  - NF PE RVU: 0.95
  - Fac PE RVU: 0.55
- **Result:** Decrease
## Status Report: CMS Requests and Relativity Assessment Issues

**67505  Retrobulbar injection; alcohol**

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**CMS 000-Day Global**
- Typically Reported with an E/M

**2022 Work RVU:** 1.18
**2022 NF PE RVU:** 1.26
**2022 Fac PE RVU:** 0.82

Result: Decrease

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

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**67515  Injection of medication or other substance into tenon’s capsule**

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**CMS 000-Day Global**
- Typically Reported with an E/M

**2022 Work RVU:** 0.75
**2022 NF PE RVU:** 0.70
**2022 Fac PE RVU:** 0.55

Result: Decrease

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

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**67820  Correction of trichiasis; epilation, by forceps only**

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**CMS High Expenditure Procedural Codes2**
- Typically Reported with an E/M

**2022 Work RVU:** 0.32
**2022 NF PE RVU:** 0.22
**2022 Fac PE RVU:** 0.30

Result: Decrease

**Referred to CPT Asst**
- Published in CPT Asst:
### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 67917 Repair of ectropion; extensive (eg, tarsal strip operations)

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### 67921 Repair of entropion; suture

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### 67922 Repair of entropion; thermocauterization

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### Status Report: CMS Requests and Relativity Assessment Issues

#### 68200 Subconjunctival Injection

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#### 68801 Dilation of Lacrimal Punctum, with or without irrigation

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#### 68810 Probing of Nasolacrimal Duct, with or without irrigation

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| 68815 | Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent | 010    |      | 010-Day Global Post-Operative Visits        | Yes       |
|       | Most Recent RUC Meeting: January 2015                                       |        |      |                                             |           |
|       | Tab: 23                                                                     |        |      |                                             |           |
|       | Specialty Developing Recommendation: AAO, AOA (optometry)                   |        |      |                                             |           |
|       | First Identified: January 2014                                              |        |      |                                             |           |
|       | Medicare Utilization: 5,830                                                 |        |      |                                             |           |
| RUC Recommendation: 3.00                                                     |        |      |                                             |           |
|       | Referred to CPT                                                             |        |      |                                             |           |
|       | Referred to CPT Asst                                                        |        |      |                                             |           |
|       | Published in CPT Asst                                                       |        |      |                                             |           |
|       | Result: Decrease                                                            |        |      |                                             |           |

| 68816 | Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation | 010    |      | 010-Day Global Post-Operative Visits        | Yes       |
|       | Most Recent RUC Meeting: January 2015                                       |        |      |                                             |           |
|       | Tab: 23                                                                     |        |      |                                             |           |
|       | Specialty Developing Recommendation: AAO, AOA (optometry)                   |        |      |                                             |           |
|       | First Identified: September 2014                                           |        |      |                                             |           |
|       | Medicare Utilization: 180                                                  |        |      |                                             |           |
| RUC Recommendation: 2.35                                                     |        |      |                                             |           |
|       | Referred to CPT                                                             |        |      |                                             |           |
|       | Referred to CPT Asst                                                        |        |      |                                             |           |
|       | Published in CPT Asst                                                       |        |      |                                             |           |
|       | Result: Decrease                                                            |        |      |                                             |           |

<p>| 69100 | Biopsy external ear                                                         | 000    |      | CMS Fastest Growing                        | Yes       |
|       | Most Recent RUC Meeting: April 2009                                          |        |      |                                             |           |
|       | Tab: 28                                                                     |        |      |                                             |           |
|       | Specialty Developing Recommendation: AAD                                      |        |      |                                             |           |
|       | First Identified: October 2008                                              |        |      |                                             |           |
|       | Medicare Utilization: 144,999                                                |        |      |                                             |           |
| RUC Recommendation: 0.81                                                     |        |      |                                             |           |
|       | Referred to CPT                                                             |        |      |                                             |           |
|       | Referred to CPT Asst                                                        |        |      |                                             |           |
|       | Published in CPT Asst                                                       |        |      |                                             |           |
|       | Result: Maintain                                                             |        |      |                                             |           |</p>
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<td>69200</td>
<td>Removal foreign body from external auditory canal; without general anesthesia</td>
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<td>Removal of Foreign Body</td>
<td>Harvard Valued - Utilization over 30,000</td>
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<td>69210</td>
<td>Removal impacted cerumen requiring instrumentation, unilateral</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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</table>
|        | **Tab:** 18  
**Specialty Developing Recommendation:** AAO-HNS                     |        |                             |                               |           |
|        | **First Identified:** October 2013                                          |        |                             |                               |           |
|        | **2020 Medicare Utilization:**                                             |        |                             |                               |           |
|        | **2022 Work RVU:**                                                          |        |                             |                               |           |
|        | **2022 NF PE RVU:**                                                         |        |                             |                               |           |
|        | **2022 Fac PE RVU:**                                                        |        |                             |                               |           |
|        | **Referred to CPT**                                                         |        |                             |                               |           |
|        | **February 2014**                                                           |        |                             |                               |           |
|        | **Published in CPT Asst:**                                                 |        |                             |                               |           |
|        | **Result:** Deleted from CPT                                               |        |                             |                               |           |

| 69433  | Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia |        | Tympanostomy                |                                | Yes       |
|        | **Most Recent RUC Meeting:** September 2011                                 |        |                             |                               |           |
|        | **Tab:** 30  
**Specialty Developing Recommendation:** AAO-HNS                     |        |                             |                               |           |
|        | **First Identified:** April 2011                                           |        |                             |                               |           |
|        | **2020 Medicare Utilization:**                                             |        |                             |                               |           |
|        | **2022 Work RVU:**                                                          |        |                             |                               |           |
|        | **2022 NF PE RVU:**                                                         |        |                             |                               |           |
|        | **2022 Fac PE RVU:**                                                        |        |                             |                               |           |
|        | **Referred to CPT**                                                         |        |                             |                               |           |
|        | **February 2014**                                                           |        |                             |                               |           |
|        | **Published in CPT Asst:**                                                 |        |                             |                               |           |
|        | **Result:** Maintain                                                        |        |                             |                               |           |

| 69801  | Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal       |        | Labyrinthotomy              |                                | Yes       |
|        | **Most Recent RUC Meeting:** October 2015                                   |        |                             |                               |           |
|        | **Tab:** 21  
**Specialty Developing Recommendation:** AAO-HNS                     |        |                             |                               |           |
|        | **First Identified:** September 2007                                        |        |                             |                               |           |
|        | **2020 Medicare Utilization:**                                             |        |                             |                               |           |
|        | **2022 Work RVU:**                                                          |        |                             |                               |           |
|        | **2022 NF PE RVU:**                                                         |        |                             |                               |           |
|        | **2022 Fac PE RVU:**                                                        |        |                             |                               |           |
|        | **Referred to CPT**                                                         |        |                             |                               |           |
|        | **Feb 2010**                                                                |        |                             |                               |           |
|        | **Published in CPT Asst:**                                                 |        |                             |                               |           |
|        | **Result:** Decrease                                                        |        |                             |                               |           |

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**Note:**
- **Global:** Indicates the level of service.
- **Issue:** Details the specific issue or request.
- **Screen:** Notes the screen criteria for evaluation.
- **Complete?** Details the completion status of the assessment.

---

**Additional Information:**
- **AAO-HNS:** American Academy of Otolaryngology-Head and Neck Surgery
- **RUC:** Relative Value Update Committee
- **RVU:** Relative Value Unit
- **CPT:** Current Procedural Terminology
- **Medicare Utilization:** Statistics on Medicare claims for the procedure.
- **Harvard Valued - Utilization over 30,000:** Indicates high utilization.
- **CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis:** Additional criteria for assessment.

---

**References:**
- **99238:** Code for Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal.
- **90290:** Code for Eustachian tube catheterization, transtympanic.
## Status Report: CMS Requests and Relativity Assessment Issues

### 69802  Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy

<table>
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<tr>
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<th>Issue:</th>
<th>Screen: CMS Fastest Growing / Site of Service Anomaly (99238-Only)</th>
<th>Complete?</th>
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### 69930  Cochlear device implantation, with or without mastoidectomy

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<th>Screen: Site of Service Anomaly</th>
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### 70030  Radiologic examination, eye, for detection of foreign body

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<th>Issue: X-Ray of Eye</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part1</th>
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<td>Tab: 28</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

**70100** Radiologic examination, mandible; partial, less than 4 views

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<th>Global: XXX</th>
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<th>Screen: High Volume Growth2</th>
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<td><strong>RUC Recommendation:</strong> RUC to submit letter to CMS specifying the inappropriate reporting of this service with the handheld device in Texas.</td>
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<td><strong>2020 Medicare Utilization:</strong> 17,628</td>
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**70210** Radiologic examination, sinuses, paranasal, less than 3 views

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<th>Screen: CMS-Other - Utilization over 30,000</th>
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**70220** Radiologic examination, sinuses, paranasal, complete, minimum of 3 views

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<td><strong>2022 Fac PE RVU:</strong> NA</td>
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<td>70250</td>
<td>Radiologic examination, skull; less than 4 views</td>
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| 70260  | Radiologic examination, skull; complete, minimum of 4 views                 |             |                          |                                             |          | 25   |
|        | Most Recent RUC Meeting: January 2019                                       |             |                          |                                             |          |      |
|        | Specialty Developing Recommendation: ACR, ASNR                               |             |                          |                                             |          |      |
|        | First Identified: October 2017                                              |             |                          |                                             |          |      |
|        | 2020 Medicare Utilization: 7,934                                             |             |                          |                                             |          |      |
|        | Referred to CPT                                                             |             |                          |                                             |          |      |
|        | Result: Decrease                                                            |             |                          |                                             |          |      |
|        | RUC Recommendation: 0.29                                                     |             |                          |                                             |          |      |
|        | Published in CPT Asst:                                                       |             |                          |                                             |          |      |
|        | Yes                                                                          |             |                          |                                             |          |      |

<p>| 70310  | Radiologic examination, teeth; partial examination, less than full mouth    |             |                          |                                             |          | 18   |
|        | Most Recent RUC Meeting: October 2013                                       |             |                          |                                             |          |      |
|        | Specialty Developing Recommendation: RUC to submit letter to CMS specifying  |             |                          |                                             |          |      |
|        | the inappropriate reporting of this service with the handheld device in Texas |             |                          |                                             |          |      |
|        | First Identified: April 2013                                                |             |                          |                                             |          |      |
|        | 2020 Medicare Utilization: 1,961                                             |             |                          |                                             |          |      |
|        | RUC Recommendation: RUC to submit letter to CMS specifying the              |             |                          |                                             |          |      |
|        | Result: Maintain                                                             |             |                          |                                             |          |      |
|        | Published in CPT Asst:                                                       |             |                          |                                             |          |      |</p>
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<td>70371</td>
<td>Complex dynamic pharyngeal and speech evaluation by cine or video recording</td>
<td>XXX</td>
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<td>Most Recent RUC Meeting: January 2019</td>
<td>Tab: 37</td>
<td>Specialty Developing Recommendation: ACR, AAFP</td>
<td>First Identified: October 2012</td>
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<tr>
<td>70373</td>
<td>Laryngography, contrast, radiological supervision and interpretation</td>
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<td>Computed tomography, head or brain; without contrast material</td>
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<td>70460</td>
<td>Computed tomography, head or brain; with contrast material(s)</td>
<td>XXX</td>
<td>CT Head/Brain</td>
<td>CMS High Expenditure Procedural Codes1</td>
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<td>70470</td>
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<td>CT Head/Brain</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
<th>Description</th>
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<th>Issue: CT – Orbit/Ear/Fossa</th>
<th>Screen: CMS-Other - Utilization over 30,000</th>
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<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<td>70480</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>Computed tomography, maxillofacial area; without contrast material</th>
<th>Global: XXX</th>
<th>Issue: CT – Maxillofacial</th>
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<td><strong>Tab:</strong> 41</td>
<td><strong>Specialty Developing Recommendation:</strong> ACR, ASNR</td>
<td><strong>First Identified:</strong> April 2013</td>
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<th>Computed tomography, maxillofacial area; with contrast material(s)</th>
<th>Global: XXX</th>
<th>Issue: CT – Maxillofacial</th>
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<th>Complete? Yes</th>
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<td><strong>Tab:</strong> 41</td>
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<tr>
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<th>Global: XXX</th>
<th>Issue: CT – Maxillofacial</th>
<th>Screen: CMS-Other - Utilization over 250,000</th>
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<th>Computed tomography, soft tissue neck; without contrast material</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>2022 Work RVU</th>
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<tr>
<td>70491</td>
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| 70492      | Computed tomography, soft tissue neck; without contrast material followed by | XXX    | CT Soft Tissue Neck | CMS High Expenditure Procedural Codes2 | Yes       | 1.62           | 5.19           | NA             |
|            | contrast material(s) and further sections                                     |        |           |                                            |           |                |                |                |
|            | **Most Recent RUC Meeting:** January 2017                                    |        |           |                                            |           |                |                |                |
|            | **Tab:** 21                                                                   |        |           |                                            |           |                |                |                |
|            | **Specialty Developing Recommendation:** ACR, ASNR                             |        |           |                                            |           |                |                |                |
|            | **First Identified:** July 2015                                              |        |           |                                            |           |                |                |                |
|            | **2020 Medicare Utilization:** 20,210                                        |        |           |                                            |           |                |                |                |
|            | **Referred to CPT**                                                           |        |           |                                            |           |                |                |                |
|            | **Published in CPT Asst:**                                                   |        |           |                                            |           |                |                |                |
|            | **Result:** Increase                                                          |        |           |                                            |           |                |                |                |

| 70496      | Computed tomographic angiography, head, with contrast material(s), including  | XXX    | CT Angiography – Head & Neck              | High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5 | Yes       | 1.75           | 6.70           | NA             |
|            | noncontrast images, if performed, and image postprocessing                    |        |                                       |                                            |           |                |                |                |
|            | **Most Recent RUC Meeting:** January 2019                                    |        |                                       |                                            |           |                |                |                |
|            | **Tab:** 37                                                                   |        |                                       |                                            |           |                |                |                |
|            | **Specialty Developing Recommendation:** ACR, ASNR                             |        |                                       |                                            |           |                |                |                |
|            | **First Identified:** February 2008                                          |        |                                       |                                            |           |                |                |                |
|            | **2020 Medicare Utilization:** 509,547                                        |        |                                       |                                            |           |                |                |                |
|            | **Referred to CPT**                                                           |        |                                       |                                            |           |                |                |                |
|            | **Published in CPT Asst:**                                                   |        |                                       |                                            |           |                |                |                |
|            | **Result:** Maintain                                                          |        |                                       |                                            |           |                |                |                |
## 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

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**2022 Work RVU:** 1.75  **2022 NF PE RVU:** 6.69  **2022 Fac PE RVU:** NA

**Result:** Maintain

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### 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

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**2022 Work RVU:** 1.35  **2022 NF PE RVU:** 5.70  **2022 Fac PE RVU:** NA

**Result:** Maintain

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### 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

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**2022 Work RVU:** 1.62  **2022 NF PE RVU:** 6.76  **2022 Fac PE RVU:** NA

**Result:** Maintain
## Status Report: CMS Requests and Relativity Assessment Issues

### 70543  
**Description:** 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 Codes

**RUC Meeting:** January 2016  
**Tab:** 39  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 55,029

**RUC Recommendation:** 2.15  
**Result:** Maintain  
**Referred to CPT Asst Published in CPT Asst:** NA

### 70544  
**Description:** Magnetic resonance angiography, head; without contrast material(s)  
**Global:** XXX  
**Issue:** Magnetic Resonance Angiography (MR) Head/Neck  
**Screen:** CMS High Expenditure Procedural Codes

**RUC Meeting:** October 2016  
**Tab:** 18  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 195,255

**RUC Recommendation:** 1.20  
**Result:** Maintain  
**Referred to CPT Asst Published in CPT Asst:** NA

### 70545  
**Description:** Magnetic resonance angiography, head; with contrast material(s)  
**Global:** XXX  
**Issue:** Magnetic Resonance Angiography (MR) Head/Neck  
**Screen:** CMS High Expenditure Procedural Codes

**RUC Meeting:** October 2016  
**Tab:** 18  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 2,796

**RUC Recommendation:** 1.20  
**Result:** Maintain  
**Referred to CPT Asst Published in CPT Asst:** NA
## Status Report: CMS Requests and Relativity Assessment Issues

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### 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**

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**Most Recent RUC Meeting:** January 2013  
**Tab:** 26  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 868,451  
**RUC Recommendation:** 2.36

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#### 71010
**Radiologic examination, chest; single view, frontal**

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**Most Recent RUC Meeting:** April 2016  
**Tab:** 07  
**Specialty Developing Recommendation:** ACR  
**First Identified:** October 2010  
**2020 Medicare Utilization:**  
**RUC Recommendation:** Deleted from CPT

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#### 71015
**Radiologic examination, chest; stereo, frontal**

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**Most Recent RUC Meeting:** April 2016  
**Tab:** 07  
**Specialty Developing Recommendation:** ACR  
**First Identified:** July 2015  
**2020 Medicare Utilization:**  
**RUC Recommendation:** Deleted from CPT
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| 71030  | Radiologic examination, chest, complete, minimum of 4 views;                |        |       | Chest-X Rays                                                           | Yes       |
|        |                                                                             | Most Recent |       |                                                                       |           |
|        |                                                                             | RUC Meeting: April 2016 |       |                                                                       |           |
|        |                                                                             | Tab: 07     |       |                                                                       |           |
|        |                                                                             | Specialty Developing Recommendation: ACR |       |                                                                       |           |
|        |                                                                             | First       |       |                                                                       |           |
|        |                                                                             | Identified: July 2015 |       |                                                                       |           |
|        |                                                                             | 2020        |       | Medicare Utilization:                                                   |           |
|        |                                                                             | 2022 Work RVU: |       |                                                                       |           |
|        |                                                                             | 2022 NF PE RVU: |       |                                                                       |           |
|        |                                                                             | 2022 Fac PE RVU: |       |                                                                       |           |
|        |                                                                             | RUC Recommendation: Deleted from CPT |       |                                                                       |           |
|        |                                                                             | Referred to CPT |       |                                                                       |           |
|        |                                                                             | Referred to CPT Asst |       |                                                                       |           |
|        |                                                                             | Published in CPT Asst |       |                                                                       |           |
|        |                                                                             | Result: Deleted from CPT |       |                                                                       |           |

| 71034  | Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy |        |       | Chest X-Rays                                                           | Yes       |
|        |                                                                             | Most Recent |       |                                                                       |           |
|        |                                                                             | RUC Meeting: April 2016 |       |                                                                       |           |
|        |                                                                             | Tab: 07     |       |                                                                       |           |
|        |                                                                             | Specialty Developing Recommendation: ACR |       |                                                                       |           |
|        |                                                                             | First       |       |                                                                       |           |
|        |                                                                             | Identified: July 2015 |       |                                                                       |           |
|        |                                                                             | 2020        |       | Medicare Utilization:                                                   |           |
|        |                                                                             | 2022 Work RVU: |       |                                                                       |           |
|        |                                                                             | 2022 NF PE RVU: |       |                                                                       |           |
|        |                                                                             | 2022 Fac PE RVU: |       |                                                                       |           |
|        |                                                                             | RUC Recommendation: Deleted from CPT |       |                                                                       |           |
|        |                                                                             | Referred to CPT |       |                                                                       |           |
|        |                                                                             | Referred to CPT Asst |       |                                                                       |           |
|        |                                                                             | Published in CPT Asst |       |                                                                       |           |
|        |                                                                             | Result: Deleted from CPT |       |                                                                       |           |

| 71035  | Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies) |        |       | Chest X-Rays                                                           | Yes       |
|        |                                                                             | Most Recent |       |                                                                       |           |
|        |                                                                             | RUC Meeting: April 2016 |       |                                                                       |           |
|        |                                                                             | Tab: 07     |       |                                                                       |           |
|        |                                                                             | Specialty Developing Recommendation: ACR |       |                                                                       |           |
|        |                                                                             | First       |       |                                                                       |           |
|        |                                                                             | Identified: July 2015 |       |                                                                       |           |
|        |                                                                             | 2020        |       | Medicare Utilization:                                                   |           |
|        |                                                                             | 2022 Work RVU: |       |                                                                       |           |
|        |                                                                             | 2022 NF PE RVU: |       |                                                                       |           |
|        |                                                                             | 2022 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

**71045  Radiologic examination, chest; single view**

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**71046  Radiologic examination, chest; 2 views**

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**71047  Radiologic examination, chest; 3 views**

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**71048  Radiologic examination, chest; 4 or more views**

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation</td>
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<td>Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator</td>
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<td>Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Screening CT of Thorax</td>
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<td>Radiologic examination, spine, cervical; 4 or 5 views</td>
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<td>X-Ray Spine</td>
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<td>Radiologic examination, spine, cervical; 6 or more views</td>
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<td>Radiologic examination, spine; thoracic, 2 views</td>
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<th>Tab</th>
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<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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# Status Report: CMS Requests and Relativity Assessment Issues

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<td>72074</td>
<td>Radiologic examination, spine; thoracic, minimum of 4 views</td>
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<td>72080</td>
<td>Radiologic examination, spine; thoracolumbar junction, minimum of 2 views</td>
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### 72072
- **Most Recent RUC Meeting:** January 2019
- **Tab:** 27
- **Specialty Developing Recommendation:** AAOS, ACR, ASNR
- **First Identified:** April 2016
- **2020 Medicare Utilization:** 139,106

- **RUC Recommendation:** 0.23
- **Result:** Increase
- **Referred to CPT:** Yes
- **Published in CPT Asst:** No

### 72074
- **Most Recent RUC Meeting:** January 2019
- **Tab:** 27
- **Specialty Developing Recommendation:** AAOS, ACR, ASNR
- **First Identified:** October 2016
- **2020 Medicare Utilization:** 9,899

- **RUC Recommendation:** 0.25
- **Result:** Increase
- **Referred to CPT:** Yes
- **Published in CPT Asst:** No

### 72080
- **Most Recent RUC Meeting:** January 2019
- **Tab:** 27
- **Specialty Developing Recommendation:** AAOS, ACR, ASNR
- **First Identified:** October 2016
- **2020 Medicare Utilization:** 38,221

- **RUC Recommendation:** 0.21
- **Result:** Decrease
- **Referred to CPT:** Yes
- **Published in CPT Asst:** No
### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

#### 72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

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**Most Recent RUC Meeting:** January 2019  
**Tab:** 27  
**Specialty Developing Recommendation:** AAOS, ACR, ASNR  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 41,713  
**2022 Work RVU:** 0.22  
**2022 NF PE RVU:** 0.98  
**2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.22  
**Referred to CPT:** October 2010  
**Result:** Maintain

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#### 72125 Computed tomography, cervical spine; without contrast material

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**Most Recent RUC Meeting:** April 2018  
**Tab:** 18  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** October 2008  
**2020 Medicare Utilization:** 1,184,668  
**2022 Work RVU:** 1.00  
**2022 NF PE RVU:** 2.97  
**2022 Fac PE RVU:** NA

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

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#### 72126 Computed tomography, cervical spine; with contrast material

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**Most Recent RUC Meeting:** April 2018  
**Tab:** 18  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 17,347  
**2022 Work RVU:** 1.22  
**2022 NF PE RVU:** 3.95  
**2022 Fac PE RVU:** NA

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

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#### 72127 Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections

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**Most Recent RUC Meeting:** April 2018  
**Tab:** 18  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** February 2009  
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**2022 Work RVU:** 1.27  
**2022 NF PE RVU:** 4.81  
**2022 Fac PE RVU:** NA

**RUC Recommendation:** 1.27  
**Referred to CPT:**  
**Result:** Maintain

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Computed tomography, thoracic spine; without contrast material

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Computed tomography, thoracic spine; with contrast material

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Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections

---

Computed tomography, lumbar spine; without contrast material

---

Computed tomography, lumbar spine; with contrast material

---

Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections

---

Computed tomography, lumbar spine; with contrast material

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Computed tomography, lumbar spine; without contrast material

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Computed tomography, thoracic spine; with contrast material
<table>
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| 72146  | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material | XXX    | MRI Neck and Lumbar Spine    | CMS High Expenditure Procedural Codes1       | Yes       | 1.48           | 4.40           | NA             |
|        | Most Recent RUC Meeting: April 2013                                           | Tab: 25| First Identified: April 2013 | 2020 Medicare Utilization: 188,463           |           |                |                |                |
|        | Specialty Developing Recommendation: ACR                                      |        | Specialty Developing         |                                              |           |                |                |                |
|        | Referred to CPT                                                               |        | Referred to CPT Asst        |                                              |           |                |                |                |
|        | Published in CPT Asst                                                         |        | Published in CPT Asst       |                                              |           |                |                |                |
|        | Result: Decrease                                                             |        | Result: Decrease            |                                              |           |                |                |                |

<p>| 72147  | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s) | XXX    | MRI Neck and Lumbar Spine    | CMS High Expenditure Procedural Codes1       | Yes       | 1.78           | 6.70           | NA             |
|        | Most Recent RUC Meeting: April 2013                                           | Tab: 25| First Identified: April 2013 | 2020 Medicare Utilization: 2,667            |           |                |                |                |
|        | Specialty Developing Recommendation: ACR                                      |        | Specialty Developing         |                                              |           |                |                |                |
|        | Referred to CPT                                                               |        | Referred to CPT Asst        |                                              |           |                |                |                |
|        | Published in CPT Asst                                                         |        | Published in CPT Asst       |                                              |           |                |                |                |
|        | Result: Decrease                                                             |        | Result: Decrease            |                                              |           |                |                |                |</p>
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**RUC Recommendation**

- **72148**
  - Tab: 25
  - Specialty Developing Recommendation: AAOS, AUR, ACR, NASS, ASNR
  - First Identified: April 2011
  - 2020 Medicare Utilization: 1,096,788
  - Result: Maintain

- **72149**
  - Tab: 25
  - Specialty Developing Recommendation: AAOS, AUR, ACR, NASS, ASNR
  - First Identified: April 2013
  - 2020 Medicare Utilization: 4,533
  - Result: Maintain

- **72156**
  - Tab: 25
  - Specialty Developing Recommendation: AAOS, AUR, ACR, NASS, ASNR
  - First Identified: April 2013
  - 2020 Medicare Utilization: 102,071
  - Result: Decrease
## Status Report: CMS Requests and Relativity Assessment Issues

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**Notes:**
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- Tab: 25
- Specialty Developing Recommendation: 2.29
- First Identified: April 2013
- 2022 Work RVU: 2.29
- 2022 NF PE RVU: 7.66
- 2022 Fac PE RVU: NA
- Medicare Utilization: 88,842
- Published in CPT Asst: Yes

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Tuesday, February 1, 2022
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## Status Report: CMS Requests and Relativity Assessment Issues

### 72196  
**Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)**

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| Most Recent RUC Meeting: October 2016 | Tab: 21 | Specialty Developing Recommendation: ACR | First Identified: July 2015 | 2020 Medicare Utilization: 2,001 |

RUC Recommendation: 1.73

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### 72197  
**Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences**

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RUC Recommendation: 2.20

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### 72200  
**Radiologic examination, sacroiliac joints; less than 3 views**

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RUC Recommendation: 0.20

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### 72202  
**Radiologic examination, sacroiliac joints; 3 or more views**

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RUC Recommendation: 0.26

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<td>72270</td>
<td>Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Radiological supervision and interpretation, percutaneous vertebroplasty,</td>
<td></td>
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<td>vertebro augmentation, or sacral augmentation (sacroplasty), including cavity</td>
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<td>creation, per vertebral body or sacrum; under fluoroscopic guidance</td>
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| 72292  | Radiological supervision and interpretation, percutaneous vertebroplasty,   |        |       |        | Yes       |
|        | vertebro augmentation, or sacral augmentation (sacroplasty), including cavity |        |       |        |           |
|        | creation, per vertebral body or sacrum; under CT guidance                    |        |       |        |           |
|        | Most Recent RUC Meeting: April 2014                                          |        |       |        |           |
|        | Specialty Developing Recommendation:                                        |        |       |        |           |
|        | First Identified: October 2012                                               |        |       |        |           |
|        | RUC Recommendation: Deleted from CPT                                          |        |       |        |           |
|        | Referred to CPT: February 2014                                               |        |       |        |           |
|        | Referred to CPT Asst: Published in CPT Asst:                                 |        |       |        |           |

| 73000  | Radiologic examination; clavicle, complete                                  |        |       |        | Yes       |
|        | Most Recent RUC Meeting: October 2018                                        |        |       |        |           |
|        | Specialty Developing Recommendation: ACR, AAOS                               |        |       |        |           |
|        | First Identified: October 2017                                               |        |       |        |           |
|        | RUC Recommendation: 0.16                                                      |        |       |        |           |
|        | Referred to CPT                                                              |        |       |        |           |
|        | Referred to CPT Asst: Published in CPT Asst:                                 |        |       |        |           |
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>73030</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
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<tbody>
<tr>
<td>73050</td>
<td>Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction</td>
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<td>ACR, AAOS</td>
<td>October 2017</td>
<td>X-Ray – Clavicle/Shoulder</td>
<td>CMS-Other - Utilization over 30,000</td>
<td>Yes</td>
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**RUC Recommendation:** 0.18

- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst

**Result:** Decrease

| 73060 | Radiologic examination; humerus, minimum of 2 views | 17  | AAOS, ACR | April 2013 | X-Ray Exams | CMS-Other - Utilization over 250,000 | Yes |

**RUC Recommendation:** 0.16

- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst

**Result:** Decrease

| 73070 | Radiologic examination, elbow; 2 views | 30  | AAOS, ACR, ASSH | April 2016 | X-Ray Elbow/Forearm | CMS-Other - Utilization over 100,000 | Yes |

**RUC Recommendation:** 0.16

- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst

**Result:** Increase
# Status Report: CMS Requests and Relativity Assessment Issues

## 73080  Radiologic examination, elbow; complete, minimum of 3 views

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<td>Tab: 30</td>
<td>Specialty Developing Recommendation: AAOS, ACR, ASSH</td>
<td>First Identified: October 2009</td>
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<td>RUC Recommendation: 0.17</td>
<td>2020 Medicare Utilization: 339,612</td>
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<td>2022 Work RVU: 0.17</td>
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<td>2022 NF PE RVU: 0.78</td>
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<td>2022 Fac PE RVU: NA</td>
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<td>2020 Medicare Utilization: 339,612</td>
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## 73090  Radiologic examination; forearm, 2 views

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<th>Screen: CMS-Other - Utilization over 100,000</th>
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<tr>
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## 73100  Radiologic examination, wrist; 2 views

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**Tuesday, February 1, 2022**

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<td>73130</td>
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<td>X-Ray of Hand/Fingers</td>
<td>Low Value-High Volume / CMS High Expenditure Procedural Codes2</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** April 2015  
**Tab:** 14  
**Specialty Developing Recommendation:** AAOS, ACR  
**First Identified:** April 2011  
**2020 Medicare Utilization:**  

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**Result:** Decrease
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Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views

Radiologic examination, hip, unilateral; complete, minimum of 2 views

Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis
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| **73522** Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views |
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| **Most Recent RUC Meeting:** April 2015  **Tab:** 14  **Specialty Developing Recommendation:** AAOS, ACR  **First Identified:** October 2014  **2020 Medicare Utilization:** 148,965 |
| **RUC Recommendation:** 0.29 |
| **Result:** Decrease |
| **Referred to CPT** October 2014  | **Purchased 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  **2020 Medicare Utilization:** 90,087 |
| **RUC Recommendation:** 0.31 |
| **Result:** Decrease |
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| 73542  | Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation |         | Sacroiliac Joint Arthrography | Different Performing Specialty from Survey | Yes |
|        |                                                                             | Most Recent RUC Meeting: April 2010 | Tab: 45 | Specialty Developing Recommendation: ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR | First Identified: October 2009 | 2020 Medicare Utilization: |
|        |                                                                             | RUC Recommendation: Deleted from CPT | Referred to CPT | Published in CPT Asst: | 2022 Work RVU: |
|        |                                                                             | Referred to CPT Asst Published in CPT Asst: | Result: Deleted from CPT | |

| 73550  | Radiologic examination, femur, 2 views                                      |         | Radiologic Exam-Hip and Pelvis | CMS-Other - Utilization over 500,000 | Yes |
|        |                                                                             | RUC Recommendation: Deleted from CPT | Referred to CPT | Published in CPT Asst: | 2022 Work RVU: |
|        |                                                                             | Referred to CPT Asst Published in CPT Asst: | Result: Deleted from CPT | |
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| 73720  | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences | XXX     | MRI Lower Extremity | CMS High Expenditure Procedural Codes2 | Yes       | 2.15           | 8.39           | NA              |
|        | Most Recent RUC Meeting: October 2016                                       | Tab: 20 | Specialty Developing Recommendation: ACR | First Identified: July 2015 | 2020 Medicare Utilization: 55,927 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: |
|        | RUC Recommendation: 2.15                                                     |         |                    |                  |           |                |                | Maintain        |

| 73721  | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material | XXX     | MRI of Lower Extremity Joint | MPC List | Yes       | 1.35           | 4.88           | NA              |
|        | Most Recent RUC Meeting: January 2012                                        | Tab: 20 | Specialty Developing Recommendation: ACR | First Identified: October 2010 | 2020 Medicare Utilization: 537,072 | Referred to CPT | Referred to CPT Asst | Published in CPT Asst: |
|        | RUC Recommendation: 1.35                                                     |         |                    |                  |           |                |                | Maintain        |
### Status Report: CMS Requests and Relativity Assessment Issues

#### 74000 Radiologic examination, abdomen; single anteroposterior view

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\[
\text{Radiologic examination, abdomen; single anteroposterior view}
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#### 7410 Radiologic examination, abdomen; anteroposterior and additional oblique and cone views

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\[
\text{Radiologic examination, abdomen; anteroposterior and additional oblique and cone views}
\]

#### 7418 Radiologic examination, abdomen; 1 view

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\[
\text{Radiologic examination, abdomen; 1 view}
\]

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Tuesday, February 1, 2022

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# Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

**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

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

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**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

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**74176** Computed tomography, abdomen and pelvis; without contrast material

- **Global:** XXX
- **Issue:** CT Abdomen/CT Pelvis
- **Screen:** CMS Fastest Growing
- **Complete?** Yes

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*Tuesday, February 1, 2022*
### Status Report: CMS Requests and Relativity Assessment Issues

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| 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 | XXX    | CT Abdomen/CT Pelvis | CMS Fastest Growing | Yes |
|        |                                                                             |        |                      |                                                                        |           |
|        | Most Recent RUC Meeting: February 2010                                      |        |                      |                                                                        |           |
|        | Tab: 16                        |        |                      |                                                                        |           |
|        | Specialty Developing Recommendation: ACR                                      |        |                      |                                                                        |           |
|        | First Identified: October 2009                                              |        |                      |                                                                        |           |
|        | 2020 Medicare Utilization: 463,043                                           |        |                      |                                                                        |           |
|        | 2022 Work RVU: 2.01                                                         |        |                      |                                                                        |           |
|        | 2022 NF PE RVU: 8.66                                                         |        |                      |                                                                        |           |
|        | RUC Recommendation: 2.01                                                     |        |                      |                                                                        |           |
|        | Referred to CPT October 2009                                                |        |                      |                                                                        |           |
|        | Referred to CPT Asst                                                        |        |                      |                                                                        |           |
|        | Published in CPT Asst                                                       |        |                      |                                                                        |           |
|        | Result: Decrease                                                            |        |                      |                                                                        |           |

| 74181  | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s) | XXX    | MRI of Abdomen        | CMS High Expenditure Procedural Codes2                                 | Yes |
|        |                                                                             |        |                      |                                                                        |           |
|        | Most Recent RUC Meeting: October 2016                                       |        |                      |                                                                        |           |
|        | Tab: 21                        |        |                      |                                                                        |           |
|        | Specialty Developing Recommendation: ACR                                      |        |                      |                                                                        |           |
|        | First Identified: July 2015                                                 |        |                      |                                                                        |           |
|        | 2020 Medicare Utilization: 100,049                                           |        |                      |                                                                        |           |
|        | 2022 Work RVU: 1.46                                                         |        |                      |                                                                        |           |
|        | 2022 NF PE RVU: 4.60                                                         |        |                      |                                                                        |           |
|        | RUC Recommendation: 1.46                                                     |        |                      |                                                                        |           |
|        | Referred to CPT                                                             |        |                      |                                                                        |           |
|        | Referred to CPT Asst                                                        |        |                      |                                                                        |           |
|        | Published in CPT Asst                                                       |        |                      |                                                                        |           |
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 74220 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

<table>
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<th>Global: XXX</th>
<th>Issue: X-Ray Exam – Upper GI</th>
<th>Screen: CMS-Other - Utilization over 100,000</th>
<th>Complete?</th>
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<tbody>
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<td>Specialty Developing Recommendation: ACR</td>
<td>First Identified: April 2016</td>
<td>2020 Medicare Utilization: 100,962</td>
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<td>Utilization:</td>
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<tr>
<td>Result:</td>
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<tr>
<td>Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study</td>
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<tr>
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#### 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

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<tr>
<th>Global: XXX</th>
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<th>Screen: CMS-Other - Utilization over 30,000-Part2</th>
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<td>Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study</td>
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<td>Result:</td>
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#### 74230 Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study

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## Status Report: CMS Requests and Relativity Assessment Issues

### 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
- **2020 Medicare Utilization**: 68,915
- **2022 Work RVU**: 0.80
- **2022 NF PE RVU**: 2.92
- **2022 Fac PE RVU**: NA
- **Result**: Increase
- **Referred to CPT Asst Published in CPT Asst**: Yes

### 74241
- **Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB**
- **Global**: Issue
- **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
- **2020 Medicare Utilization**: 68,915
- **2022 Work RVU**: 0.80
- **2022 NF PE RVU**: 2.92
- **2022 Fac PE RVU**: NA
- **Result**: Deleted from CPT
- **Referred to CPT Asst Published in CPT Asst**: Yes

### 74245
- **Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images**
- **Global**: Issue
- **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
- **2020 Medicare Utilization**: 68,915
- **2022 Work RVU**: 0.80
- **2022 NF PE RVU**: 2.92
- **2022 Fac PE RVU**: NA
- **Result**: Deleted from CPT
- **Referred to CPT Asst Published in CPT Asst**: Yes
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>74247</td>
<td>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</td>
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<td>Radiologic small intestine follow-through study, including multiple serial images (list separately in addition to code for primary procedure for upper gi radiologic examination)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td></td>
<td>specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through</td>
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<td><strong>2022 NF PE RVU:</strong></td>
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| 74250  | Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study | XXX    | Lower Gastrointestinal Tract Imaging | CMS-Other - Utilization over 30,000 | Yes       |
|        | **Most Recent RUC Meeting:** October 2018                                    |        |                             |                         |           |
|        | **Tab:** 11  Specialty Developing Recommendation:** ACR                    |        |                             |                         |           |
|        | **First Identified:** October 2017                                           |        |                             |                         |           |
|        | **2020 Medicare Utilization:**                                               |        |                             |                         |           |
|        | **2022 Work RVU:**                                                           | 0.81   |                             |                         |           |
|        | **2022 NF PE RVU:**                                                          | 2.90   |                             |                         |           |
|        | **2022 Fac PE RVU:**                                                         | NA     |                             |                         |           |
|        | RUC Recommendation: 0.81                                                     |        |                             |                         |           |
|        | Referred to CPT May 2018                                                     |        |                             |                         |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                             |                         |           |
|        | **Result:** Increase                                                         |        |                             |                         |           |

| 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 | XXX    | Lower Gastrointestinal Tract Imaging | CMS-Other - Utilization over 30,000 | Yes       |
|        | **Most Recent RUC Meeting:** October 2018                                    |        |                             |                         |           |
|        | **Tab:** 11  Specialty Developing Recommendation:** ACR                    |        |                             |                         |           |
|        | **First Identified:** October 2017                                           |        |                             |                         |           |
|        | **2020 Medicare Utilization:**                                               |        |                             |                         |           |
|        | **2022 Work RVU:**                                                           | 1.17   |                             |                         |           |
|        | **2022 NF PE RVU:**                                                          | 10.28  |                             |                         |           |
|        | **2022 Fac PE RVU:**                                                         | NA     |                             |                         |           |
|        | RUC Recommendation: 1.17                                                     |        |                             |                         |           |
|        | Referred to CPT May 2018                                                     |        |                             |                         |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                             |                         |           |
|        | **Result:** Increase                                                         |        |                             |                         |           |
### Status Report: CMS Requests and Relativity Assessment Issues

#### 74260 Duodenography, hypotonic
- **Global:**
- **Issue:** X-Ray Exam – Small Intestine/Colon
- **Screen:** CMS-Other - Utilization over 30,000
- **Complete?** Yes

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<tbody>
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#### 74270 Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study
- **Global:** XXX
- **Issue:** Lower Gastrointestinal Tract Imaging
- **Screen:** CMS-Other - Utilization over 30,000
- **Complete?** Yes

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#### 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 Gastrointestinal Tract Imaging
- **Screen:** Harvard Valued - Utilization over 30,000
- **Complete?** Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation</td>
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<td>Result: Decrease</td>
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| 74301  | Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (list separately in addition to code for primary procedure) | ZZZ    | X-Rays at Surgery Add-On     | CMS-Other - Utilization over 30,000-Part2 | Yes       |
|        | Most Recent RUC Meeting: October 2020                                         |        |                              |                               |           |
|        | Specialty Developing Recommendation: ACR, ACS, SAGES, SIR                    |        |                              |                               |           |
|        | First Identified: October 2018                                               |        |                              |                               |           |
|        | 2020 Medicare Utilization: 77                                                 |        |                              |                               |           |
|        | 2022 Work RVU: 0.00                                                           |        |                              |                               |           |
|        | 2022 NF PE RVU: 0.00                                                          |        |                              |                               |           |
|        | 2022 Fac PE RVU: NA                                                           |        |                              |                               |           |
|        | RUC Recommendation: 0.21                                                      |        |                              |                               |           |
|        | Referred to CPT                                                              |        |                              |                               |           |
|        | Referred to CPT Asst                                                          |        |                              |                               |           |
|        | Published in CPT Asst                                                         |        |                              |                               |           |
|        | Result: Maintain                                                              |        |                              |                               |           |

<p>| 74305  | Deleted from CPT                                                              |        |                              | Codes Reported Together 75% or More-Part2 | Yes       |
|        | Most Recent RUC Meeting: October 2015                                         |        |                              |                               |           |
|        | Specialty Developing Recommendation: ACR, SIR                                  |        |                              |                               |           |
|        | First Identified: October 2012                                               |        |                              |                               |           |
|        | 2020 Medicare Utilization:                                                     |        |                              |                               |           |
|        | 2022 Work RVU:                                                                |        |                              |                               |           |
|        | 2022 NF PE RVU:                                                               |        |                              |                               |           |
|        | 2022 Fac PE RVU:                                                              |        |                              |                               |           |
|        | RUC Recommendation: Deleted from CPT                                          |        |                              |                               |           |
|        | Referred to CPT                                                              |        |                              |                               |           |
|        | Referred to CPT Asst                                                          |        |                              |                               |           |
|        | Published in CPT Asst                                                         |        |                              |                               |           |
|        | Result: Deleted from CPT                                                       |        |                              |                               |           |</p>
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<tr>
<th>CMS Code</th>
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<tbody>
<tr>
<td>74320</td>
<td>Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation</td>
<td>Yes</td>
<td>Percutaneous Biliary Procedures Bundling</td>
<td>Codes Reported Together 75% or More-Part2</td>
<td>Yes</td>
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<tr>
<td>74327</td>
<td>Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation</td>
<td>Yes</td>
<td>Percutaneous Biliary Procedures Bundling</td>
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<tr>
<td>74328</td>
<td>Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation</td>
<td>Yes</td>
<td>X-Rays at Surgery Add-On</td>
<td>CMS-Other - Utilization over 30,000-Part2</td>
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<tr>
<td><strong>74329</strong> Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation</td>
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<td>X-Rays at Surgery Add-On</td>
<td>CMS-Other - Utilization over 30,000-Part2</td>
<td>Yes</td>
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<tr>
<td>RUC Meeting: April 2019</td>
<td>Tab: 19</td>
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<td>2022 Fac PE RVU: NA</td>
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</table>

| **74330** Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation | XXX    | X-Rays at Surgery Add-On | CMS-Other - Utilization over 30,000-Part2 | Yes       |
| RUC Meeting: April 2019                                                            | Tab: 19| First      | 2020 Medicare Utilization: 11,873          |           |
| Most Recent RUC Meeting: April 2019                                                |        | Identified: October 2018                         |           |
| RUC Recommendation: 0.70                                                            |        | 2022 Work RVU: 0.00                             |           |
| Referred to CPT                                                                    |        | 2022 NF PE RVU: 0.00                            |           |
| Referred to CPT Asst                                                               |        | 2022 Fac PE RVU: NA                             |           |
| Result: Decrease                                                                  |        | Complete? Yes                                   |           |
| Published in CPT Asst                                                              |        |                                                       |

| **74400** Urography (pyelography), intravenous, with or without kub, with or without tomography | XXX    | Contrast X-Ray Exams | Harvard Valued - Utilization over 30,000 | Yes       |
| RUC Meeting: September 2011                                                        | Tab: 31| First      | 2020 Medicare Utilization: 3,849          |           |
| Most Recent RUC Meeting: September 2011                                            |        | Identified: April 2011                           |           |
| RUC Recommendation: 0.49                                                            |        | 2022 Work RVU: 0.49                             |           |
| Referred to CPT                                                                    |        | 2022 NF PE RVU: 3.61                            |           |
| Referred to CPT Asst                                                               |        | 2022 Fac PE RVU: NA                             |           |
| Result: Maintain                                                                  |        | Complete? Yes                                   |           |
| Published in CPT Asst                                                              |        |                                                       |

| **74420** Urography, retrograde, with or without kub                                | XXX    | X-Ray Urinary Tract | CMS-Other - Utilization over 100,000       | Yes       |
| RUC Meeting: April 2017                                                            | Tab: 26| First      | 2020 Medicare Utilization: 144,313        |           |
| Most Recent RUC Meeting: April 2017                                                |        | Identified: April 2016                            |           |
| RUC Recommendation: 0.52                                                            |        | 2022 Work RVU: 0.52                             |           |
| Referred to CPT                                                                    |        | 2022 NF PE RVU: 1.74                            |           |
| Referred to CPT Asst                                                               |        | 2022 Fac PE RVU: NA                             |           |
| Result: Increase                                                                  |        | Complete? Yes                                   |           |
| Published in CPT Asst                                                              |        |                                                       |
## Status Report: CMS Requests and Relativity Assessment Issues

### 74425  Urography, antegrade, radiological supervision and interpretation

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<tbody>
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### 74475  Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation

<table>
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<tr>
<th>Global:</th>
<th>Issue: Genitourinary Catheter Procedures</th>
<th>Screen: Codes Reported Together 75% or More-Part2</th>
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<td>Specialty Developing Recommendation: ACR, SIR</td>
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### 74480  Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation

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<th>Screen: Codes Reported Together 75% or More-Part2</th>
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<tbody>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<th>Code</th>
<th>Description</th>
<th>Global: XXX</th>
<th>Issue: Abdominal Aortography</th>
<th>Screen: CMS Other - Utilization over 30,000</th>
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<tbody>
<tr>
<td>75574</td>
<td>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)</td>
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**Most Recent RUC Meeting:** January 2021

**Tab:** 29

**Specialty Developing Recommendation:** ACR, SIR, ACC

**First Identified:** May 2013

**2020 Medicare Utilization:** 83,373

**2022 Work RVU:** 2.40

**2022 NF PE RVU:** 7.51

**2022 Fac PE RVU:** NA

**Result:** Remove from screen

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<th>Screen: CMS Other - Utilization over 30,000</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>75625</td>
<td>Aortography, abdominal, by serialography, radiological supervision and interpretation</td>
<td>Maintain</td>
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**Most Recent RUC Meeting:** October 2018

**Tab:** 19

**Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS

**First Identified:** October 2017

**2020 Medicare Utilization:** 81,691

**2022 Work RVU:** 1.44

**2022 NF PE RVU:** 2.17

**2022 Fac PE RVU:** NA

**Result:** Increase

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<th>Screen: CMS Other - Utilization over 30,000</th>
<th>Complete?</th>
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</thead>
<tbody>
<tr>
<td>75630</td>
<td>Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation</td>
<td>Maintain</td>
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**Most Recent RUC Meeting:** October 2018

**Tab:** 19

**Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS

**First Identified:** October 2017

**2020 Medicare Utilization:** 21,287

**2022 Work RVU:** 2.00

**2022 NF PE RVU:** 2.51

**2022 Fac PE RVU:** NA

**Result:** Increase
## Status Report: CMS Requests and Relativity Assessment Issues

### 75635
**Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

<table>
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<th>Issue: CT Angiography of Abdominal Arteries</th>
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### 75650
**Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

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### 75671
**Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

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### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** October 2018  
**Tab:** 20  
**Specialty Developing Recommendation:** SCAI, SIR, SVS  
**First Identified:** October 2017  
**2020 Medicare Utilization:** 75,593  
**2022 Work RVU:** 1.01  
**2022 NF PE RVU:** 1.80  
**2022 Fac PE RVU:** NA  
**Result:** Increase  

- Referred to CPT  
- Published in CPT Asst: Yes

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**Most Recent RUC Meeting:** April 2009  
**Tab:** 9  
**Specialty Developing Recommendation:** SVS, SIR, ACR  
**First Identified:** February 2008  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Result:** Deleted from CPT  

- Referred to CPT  
- Published in CPT Asst: Yes

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<th>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</th>
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**First Identified:** October 2015  
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- Referred to CPT  
- Published in CPT Asst: Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>75940</td>
<td>Percutaneous placement of IVC filter, radiological supervision and interpretation</td>
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<td>Major Vein Revision</td>
<td>Codes Reported Together 75% or More-Part1</td>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 45  
**Specialty Developing Recommendation:** ACR, SIR, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:**  
**RUC Recommendation:** Deleted from CPT  
**Result:** Referred to CPT  
**Referred to CPT Asst:** February 2011  
**Published in CPT Asst:**

| 75945 | Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel |        | Intravascular Ultrasound | Final Rule for 2015              | Yes       |

**Most Recent RUC Meeting:** January 2015  
**Tab:** 07  
**Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS  
**First Identified:** July 2014  
**2020 Medicare Utilization:**  
**RUC Recommendation:** Deleted from CPT  
**Result:** Referred to CPT  
**Referred to CPT Asst:** October 2014  
**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) |        | Intravascular Ultrasound | Final Rule for 2015              | Yes       |

**Most Recent RUC Meeting:** January 2015  
**Tab:** 07  
**Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS  
**First Identified:** July 2014  
**2020 Medicare Utilization:**  
**RUC Recommendation:** Deleted from CPT  
**Result:** Referred to CPT  
**Referred to CPT Asst:** October 2014  
**Published in CPT Asst:**
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<tr>
<td>75952</td>
<td>Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation</td>
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<td>October 2015</td>
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<td>75953</td>
<td>Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation</td>
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<td>75954</td>
<td>Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation</td>
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<td>SVS, SIR, STS, AATS</td>
<td>January 2017</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 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

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**Most Recent RUC Meeting:** October 2012  
**Tab:** 27  
**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS  
**First Identified:** 2020 Medicare Utilization:  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT** February 2013  
**Referred to CPT Asst** Published in CPT Asst:  
**Result:** Deleted from CPT

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### 75961
Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation

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**Most Recent RUC Meeting:** April 2010  
**Tab:** 45  
**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS  
**First Identified:** February 2010  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT** June 2011  
**Referred to CPT Asst** Published in CPT Asst:  
**Result:** Deleted from CPT

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### 75962
Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation

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<td>Open and Percutaneous Transluminal Angioplasty</td>
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**Most Recent RUC Meeting:** January 2016  
**Tab:** 15  
**Specialty Developing Recommendation:** ACR, SIR, SVS  
**First Identified:** April 2010  
**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

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<td>75964</td>
<td>Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliocostal, or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
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<td>Open and Percutaneous Transluminal Angioplasty</td>
<td>High Volume Growth1</td>
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| 75966 | Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation |        | Open and Percutaneous Transluminal Angioplasty | Codes Reported Together 75% or More-Part3 | Yes |

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| 75968 | Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) |        | Open and Percutaneous Transluminal Angioplasty | Codes Reported Together 75% or More-Part3 | Yes |

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<td>Open and Percutaneous Transluminal Angioplasty</td>
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<td>75980</td>
<td>Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation</td>
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<td>75982</td>
<td>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</td>
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<td>Percutaneous Biliary Procedures Bundling</td>
<td>Codes Reported Together 75% or More-Part2</td>
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Status Report: CMS Requests and Relativity Assessment Issues

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

2020 Medicare Utilization: 19,707

2022 Work RVU: 0.83  2022 NF PE RVU: 2.03  2022 Fac PE RVU: NA

RUC Recommendation: 0.83

Referred to CPT RAW will assess Oct 2018
Referred to CPT Asst Published in CPT Asst:

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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
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

2020 Medicare Utilization:

2022 Work RVU:
2022 NF PE RVU:
2022 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010
Referred to CPT Asst Published in CPT Asst:
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<td><strong>75995</strong> Revised to Category III</td>
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<td><strong>Global:</strong> Transluminal Arthrectomy</td>
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<tr>
<td><strong>Issue:</strong> Transluminal Arthrectomy</td>
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<tr>
<td><strong>Screen:</strong> High Volume Growth1</td>
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<td><strong>Complete?</strong> Yes</td>
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| Most Recent RUC Meeting: April 2008                           |
| Tab: 57                                                      |
| Specialty Developing Recommendation: SIR, ACR, SVS           |
| First Identified: April 2008                                 |
| 2020 Medicare Utilization:                                   |
| RUC Recommendation: Deleted from CPT                         |
| Referred to CPT February 2010                               |
| Referred to CPT Asst Published in CPT Asst:                  |
| Result: Deleted from CPT                                      |

| **75996** Revised to Category III                             |
| **Global:** Transluminal Arthrectomy                          |
| **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                                 |
| 2020 Medicare Utilization:                                   |
| RUC Recommendation: Deleted from CPT                         |
| Referred to CPT February 2010                               |
| Referred to CPT Asst Published in CPT Asst:                  |
| Result: Deleted from CPT                                      |

| **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                              |
| 2020 Medicare Utilization:                                  |
| RUC Recommendation: 0.30                                     |
| Referred to CPT                                              |
| Referred to CPT Asst Published in CPT Asst:                  |
| Result: Increase                                             |
## Status Report: CMS Requests and Relativity Assessment Issues

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<th>76001</th>
<th>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)</th>
<th>Global:</th>
<th>Issue: Fluoroscopy</th>
<th>Screen: CMS-Other - Utilization over 100,000</th>
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<td>2022 NF PE RVU:</td>
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<th>76098</th>
<th>Radiological examination, surgical specimen</th>
<th>Global: XXX</th>
<th>Issue: X-Ray Exam Specimen</th>
<th>Screen: CMS-Other - Utilization over 30,000</th>
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<td>Specialty Developing Recommendation: ACR</td>
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<th>76100</th>
<th>Radiologic examination, single plane body section (e.g., tomography), other than with urography</th>
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<th>Issue: Fluoroscopy</th>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>CMS Request - Practice Expense Review</td>
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<td>76102</td>
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<td>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</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 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

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**Most Recent RUC Meeting:** October 2021  
**Tab:** 17  
**Specialty Developing Recommendation:** ACR, ASNR  
**First Identified:** July 2019  
**2020 Medicare Utilization:** 155,353  
**2022 Work RVU:** 0.79  
**2022 NF PE RVU:** 1.30  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.79  
**Result:** Maintain

Referral Summary:
- **Referral:** CPT
- **Published in CPT Asst:** No

#### 76510
Ophthalmic ultrasound, diagnostic; b-scan and quantitative a-scan performed during the same patient encounter

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**Most Recent RUC Meeting:** October 2016  
**Tab:** 23  
**Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry)  
**First Identified:** April 2016  
**2020 Medicare Utilization:** 11,064  
**2022 Work RVU:** 0.70  
**2022 NF PE RVU:** 1.33  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.70  
**Result:** Decrease

Referral Summary:
- **Referral:** CPT
- **Published in CPT Asst:** No

#### 76511
Ophthalmic ultrasound, diagnostic; quantitative a-scan only

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**Most Recent RUC Meeting:** October 2016  
**Tab:** 23  
**Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry)  
**First Identified:** April 2016  
**2020 Medicare Utilization:** 3,275  
**2022 Work RVU:** 0.64  
**2022 NF PE RVU:** 1.01  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.64  
**Result:** Decrease

Referral Summary:
- **Referral:** CPT
- **Published in CPT Asst:** No

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## Status Report: CMS Requests and Relativity Assessment Issues

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# Status Report: CMS Requests and Relativity Assessment Issues

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| 76519  | Ophthalmic biometry by ultrasound echography, a-scan; with intraocular lens | XXX    | Ophthalmic Biometry       | CMS High Expenditure Procedural Codes2      | Yes       | 2022 | 0.54     | 1.42      | NA         |
|        | power calculation                                                            |         |                            |                                              |           |      |          |           |            |
|        | Most Recent RUC Meeting: April 2016                                        |         |                            |                                              |           |      |          |           |            |
|        | Tab: 36 Specialty Developing Recommendation: AAO, AOA (optometry)          |         |                            |                                              |           |      |          |           |            |
|        | First Identified: July 2015                                                 |         |                            |                                              |           |      |          |           |            |
|        | Medicare Utilization: 126,280                                               |         |                            |                                              |           |      |          |           |            |
|        | Referral to CPT, Referred to CPT Ass                                      |         |                            |                                              |           |      |          |           |            |
|        | Published in CPT Ass                                                       |         |                            |                                              |           |      |          |           |            |
|        | Result: Maintain                                                            |         |                            |                                              |           |      |          |           |            |

| 76536  | Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation | XXX    | Soft Tissue Ultrasound   | CMS Fastest Growing                         | Yes       | 2022 | 0.56     | 2.76      | NA         |
|        | Most Recent RUC Meeting: April 2009                                        |         |                            |                                              |           |      |          |           |            |
|        | Tab: 29 Specialty Developing Recommendation: ACR, ASNR, TES, AACE          |         |                            |                                              |           |      |          |           |            |
|        | First Identified: October 2008                                              |         |                            |                                              |           |      |          |           |            |
|        | Medicare Utilization: 783,204                                               |         |                            |                                              |           |      |          |           |            |
|        | Referral to CPT, Referred to CPT Ass                                      |         |                            |                                              |           |      |          |           |            |
|        | Published in CPT Ass                                                       |         |                            |                                              |           |      |          |           |            |
|        | Result: Maintain                                                            |         |                            |                                              |           |      |          |           |            |

| 76604  | Ultrasound, chest (includes mediastinum), real time with image documentation | XXX    | Ultrasound Exam - Chest   | CMS-Other - Utilization over 30,000          | Yes       | 2022 | 0.59     | 1.10      | NA         |
|        | Most Recent RUC Meeting: April 2018                                        |         |                            |                                              |           |      |          |           |            |
|        | Tab: 24 Specialty Developing Recommendation: ACR                            |         |                            |                                              |           |      |          |           |            |
|        | First Identified: October 2017                                              |         |                            |                                              |           |      |          |           |            |
|        | Medicare Utilization: 96,497                                                |         |                            |                                              |           |      |          |           |            |
|        | Referral to CPT, Referred to CPT Ass                                      |         |                            |                                              |           |      |          |           |            |
|        | Published in CPT Ass                                                       |         |                            |                                              |           |      |          |           |            |
|        | Result: Increase                                                            |         |                            |                                              |           |      |          |           |            |

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### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

#### 76965  
Ultrasonic guidance for interstitial radioelement application

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- **Tab:** 21
- **Specialty Developing Recommendation:** NO INTEREST
- **First Identified:** July 2013
- **2020 Medicare Utilization:** 5,396

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

#### 76970  
Ultrasound study follow-up (specify)

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<tbody>
<tr>
<td></td>
<td>IMRT with Ultrasound Guidance</td>
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</table>

- **Most Recent RUC Meeting:** October 2019
- **Tab:** 17
- **Specialty Developing Recommendation:** ACS, ACR, AACE
- **First Identified:** February 2008
- **2020 Medicare Utilization:** 20,100

- **RUC Recommendation:** Deleted from CPT
- **Result:** Deleted from CPT
- **Referred to CPT**
- **Referred to CPT Asst**
- **Published in CPT Asst:**

#### 76998  
Ultrasonic guidance, intraoperative

<table>
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<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part1</th>
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<tr>
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- **Most Recent RUC Meeting:** October 2019
- **Tab:** 17
- **Specialty Developing Recommendation:** STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS
- **First Identified:** January 2019
- **2020 Medicare Utilization:** 26,174

- **RUC Recommendation:** Refer to CPT
- **Result:**
- **Referred to CPT**
- **Referred to CPT Asst**
- **Published in CPT Asst:**

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### 76XX0

**Global:** Neuromuscular Ultrasound  
**Issue:** New Technology/New Services  
**Complete?** Yes

<table>
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<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
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<th>2020 Medicare Utilization</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<tr>
<td>January 2022</td>
<td></td>
<td>AAN, AANEM, AAPM&amp;R, ACR, ACRh, APMA</td>
<td>October 2021</td>
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### 77001

**Global:** ZZZ  
**Issue:** PICC Line Procedures  
**Complete?** Yes

> 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)

<table>
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<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
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<tr>
<td>January 2018</td>
<td>09</td>
<td>AANS, AANEM, AAPM, AAPM&amp;R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS</td>
<td>January 2012</td>
<td>286,956</td>
<td>0.38</td>
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### 77002

**Global:** ZZZ  
**Issue:** Somatic Nerve Injections  
**Complete?** Yes

> Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (list separately in addition to code for primary procedure)

<table>
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<tr>
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<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
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<tr>
<td>October 2021</td>
<td>05</td>
<td>AAPM, AAPM&amp;R, ACR, SIR, SIS</td>
<td>January 2012</td>
<td>466,846</td>
<td>0.54</td>
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</table>
# 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)**

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<td></td>
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<td>2022 Fac PE RVU:</td>
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**Most Recent RUC Meeting:** October 2021  
**Tab:** 05  
**Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS  
**First Identified:** October 2010  
**2020 Medicare Utilization:** 26,632  
**RUC Recommendation:** 0.60  
**Referred to CPT:** October 2015  
**Result:** Maintain

## 77011  
**Computed tomography guidance for stereotactic localization**

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<th>CMS Request - Practice Expense Review</th>
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**Most Recent RUC Meeting:** October 2010  
**Tab:** 15  
**Specialty Developing Recommendation:** ASTRO, ACRO  
**First Identified:**  
**2020 Medicare Utilization:** 3,549  
**RUC Recommendation:** New PE inputs  
**Referred to CPT**  
**Result:** PE Only

## 77012  
**Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation**

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<th>Lung Biopsy-CT Guidance Bundle</th>
<th>Screen:</th>
<th>CMS-Other - Utilization over 100,000 / Codes Reported Together 75% or More-Part4</th>
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<td>2022 Fac PE RVU:</td>
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**Most Recent RUC Meeting:** April 2019  
**Tab:** 05  
**Specialty Developing Recommendation:** ACR, SIR  
**First Identified:** April 2016  
**2020 Medicare Utilization:** 185,999  
**RUC Recommendation:** Bundled 32405 and 77012. 1.50  
**Referred to CPT:** February 2019  
**Result:** Increase
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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? Yes

Most Recent RUC Meeting: October 2021  
Tab: 20  Specialty Developing Recommendation: ASTRO, ACR  
First Identified: October 2010  
2020 Medicare Utilization: 2,333,203  

RUC Recommendation: Remove from screen  
Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

Result: Maintain

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  
2020 Medicare Utilization:

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

Result: Deleted from CPT

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  
2020 Medicare Utilization:

Referred to CPT  
Referred to CPT Asst  
Published in CPT Asst:

Result: Deleted from CPT

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### 77046  
**Global:** XXX  
**Issue:** Breast MRI with Computer-Aided Detection  
**Screen:** CMS High Expenditure Procedural Codes2  
**Complete?** Yes

<table>
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<th>Tab: 06</th>
<th>Specialty Developing Recommendation: ACR</th>
<th>First Identified: June 2017</th>
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Referral to CPT: June 2017  
Published in CPT Asst: Yes  
Result: Decrease

### 77047  
**Global:** XXX  
**Issue:** Breast MRI with Computer-Aided Detection  
**Screen:** CMS High Expenditure Procedural Codes2  
**Complete?** Yes

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: October 2017</th>
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<th>Specialty Developing Recommendation: ACR</th>
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Referral to CPT: June 2017  
Published in CPT Asst: Yes  
Result: Decrease

### 77048  
**Global:** XXX  
**Issue:** Breast MRI with Computer-Aided Detection  
**Screen:** CMS High Expenditure Procedural Codes2  
**Complete?** Yes

<table>
<thead>
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Referral to CPT: June 2017  
Published in CPT Asst: Yes  
Result: Increase

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**Magnetic resonance imaging, breast, without contrast material; unilateral**

**Magnetic resonance imaging, breast, without contrast material; bilateral**

**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**
## 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**

<table>
<thead>
<tr>
<th>Global:</th>
<th>XXX</th>
<th>Issue:</th>
<th>Breast MRI with Computer-Aided Detection</th>
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<tbody>
<tr>
<td>Screen:</td>
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<td>Complete?</td>
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<td>Tab:</td>
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<td>First Identified:</td>
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<td>2020 Medicare Utilization:</td>
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<td>Referred to CPT:</td>
<td>June 2017</td>
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<td>Published in CPT Asst:</td>
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### 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)**

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue:</th>
<th>Mammography-Computer Aided Detection Bundling</th>
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<tbody>
<tr>
<td>Screen:</td>
<td>CMS-Other - Utilization over 250,000 / Final Rule for 2015</td>
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<td>Complete?</td>
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<table>
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<th>January 2016</th>
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<td>Tab:</td>
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<tr>
<td>Specialty Developing Recommendation:</td>
<td>ACR</td>
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<tr>
<td>First Identified:</td>
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<td>2020 Medicare Utilization:</td>
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<td>October 2015</td>
</tr>
<tr>
<td>Published in CPT Asst:</td>
<td></td>
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</table>

### 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)**

<table>
<thead>
<tr>
<th>Global:</th>
<th>Issue:</th>
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<tbody>
<tr>
<td>Screen:</td>
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<td>Tab:</td>
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<td>77055</td>
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<tr>
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<td>Mammography; bilateral</td>
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<td>Mammography-Computer Aided Detection Bundling</td>
<td>CMS-Other - Utilization over 250,000 / Final Rule for 2015</td>
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<td>77057</td>
<td>Screening mammography, bilateral (2-view study of each breast)</td>
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<td>CMS-Other - Utilization over 250,000 / Final Rule for 2015</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Breast MRI with Computer-Aided Detection</td>
<td>CMS High Expenditure Procedural Codes2</td>
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<td>77059</td>
<td>Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral</td>
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<td>77065</td>
<td>Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral</td>
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<td>77066</td>
<td>Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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**Screen:** Final Rule for 2015  
**Screen:** CMS-Other - Utilization over 30,000  
**Screen:** CMS-Other - Utilization over 30,000  
**Screen:** CMS-Other - Utilization over 30,000  

**2022 Work RVU:** 0.76  
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**2022 Fac PE RVU:** NA  
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**2022 Fac PE RVU:** NA  
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**2022 Fac PE RVU:** NA  

**Medicare Utilization:** 0.76  
**Medicare Utilization:** 1.06NA  
**Medicare Utilization:** 0.44  
**Medicare Utilization:** 2.38NA  

**Screen:** Referred to CPT Asst Published in CPT Asst:
## Status Report: CMS Requests and Relativity Assessment Issues

### 77076  Radiologic examination, osseous survey, infant

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### 77077  Joint survey, single view, 2 or more joints (specify)

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### 77079  Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

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Tuesday, February 1, 2022
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<td><strong>77083</strong> Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 77261  Therapeutic radiology treatment planning; simple

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### 77262  Therapeutic radiology treatment planning; intermediate

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### 77263  Therapeutic radiology treatment planning; complex

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<td>3-dimensional radiotherapy plan, including dose-volume histograms</td>
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<td>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</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 20  
**Specialty Developing Recommendation:**  
**First Identified:** October 2010  
**2020 Medicare Utilization:** 34,096  
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**Referred to CPT Asst:**  
**Published in CPT Asst:** No

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**Most Recent RUC Meeting:** April 2014  
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**Referred to CPT:** February 2014  
**Referred to CPT Asst:**  
**Published in CPT Asst:** No

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**Most Recent RUC Meeting:** April 2014  
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**Referred to CPT:** February 2014  
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>Continuing Medical Physics Consultation-PE Only</td>
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<td>Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based</td>
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<td>Radiation Treatment Delivery, Stereotactic Radiosurgery</td>
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#### 77336
- **RUC Meeting:** April 2013
- **Most Recent RUC Meeting:** April 2013
- **Tab:** 31
- **Specialty Developing Recommendation:** ASTRO
- **Issue:** Continuing Medical Physics Consultation-PE Only
- **Global:** XXX
- **Screen:** CMS Request - Final Rule for 2013
- **Complete?** Yes
- **First Identified:** October 2012
- **2020 Medicare Utilization:** 376,051
- **2022 Work RVU:** 0.00
- **2022 NF PE RVU:** 2.35
- **2022 Fac PE RVU:** NA
- **RUC Recommendation:** New PE Inputs
- **Result:** PE Only

#### 77338
- **RUC Meeting:** April 2013
- **Most Recent RUC Meeting:** April 2013
- **Tab:** 28
- **Specialty Developing Recommendation:**
- **Issue:** IMRT - PE Only
- **Global:** XXX
- **Screen:** Services with Stand-Alone PE Procedure Time
- **Complete?** Yes
- **First Identified:** October 2012
- **2020 Medicare Utilization:** 163,112
- **2022 Work RVU:** 4.29
- **2022 NF PE RVU:** 8.92
- **2022 Fac PE RVU:** NA
- **RUC Recommendation:** New PE Inputs
- **Result:** PE Only

#### 77371
- **RUC Meeting:** April 2009
- **Most Recent RUC Meeting:** April 2009
- **Tab:** 30
- **Specialty Developing Recommendation:** ASTRO
- **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery
- **Global:** XXX
- **Screen:** CMS Request - Practice Expense Review
- **Complete?** Yes
- **First Identified:** NA
- **2020 Medicare Utilization:** 122
- **2022 Work RVU:** 0.00
- **2022 NF PE RVU:** 0.00
- **2022 Fac PE RVU:** 0.00
- **RUC Recommendation:** New PE inputs
- **Result:** PE Only
### 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

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#### 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

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#### 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

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### Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
## Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1</td>
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**First Identified:**
- 77418: October 2008
- 77421: February 2010
- 77422: November 2014

**Referral to CPT:**
- 77418: October 2013
- 77421: October 2013
- 77422: November 2014

**Referral to CPT Asst:**
- 77418: Published in CPT Asst: Nov 2009 and Q&A - Mar 2010
- 77421: Published in CPT Asst: No
- 77422: Published in CPT Asst: No

**Screen:**
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- 77422: Contractor Price
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### Status Report: CMS Requests and Relativity Assessment Issues

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## 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  | **2020 Medicare Utilization:** 14,598  | **2022 Work RVU:** 3.80  | **2022 NF PE RVU:** 13.48  | **2022 Fac PE RVU:** NA

**RUC Recommendation:** 3.80  | **Referred to CPT** October 2014  | **Result:** Decrease  | **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  | **2020 Medicare Utilization:** 3,869  | **2022 Work RVU:** 5.40  | **2022 NF PE RVU:** 20.27  | **2022 Fac PE RVU:** NA

**RUC Recommendation:** 5.40  | **Referred to CPT** October 2014  | **Result:** Decrease  | **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  | **2020 Medicare Utilization:**  | **2022 Work RVU:**  | **2022 NF PE RVU:**  | **2022 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT  | **Referred to CPT** February 2015  | **Result:** Deleted from CPT  | **Published in CPT Asst:**
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**Status Report: CMS Requests and Relativity Assessment Issues**

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## Status Report: CMS Requests and Relativity Assessment Issues

### 77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels
- **Global:** Surface Radionuclide High Does Rate Brachytherapy
- **Issue:** Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels
- **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure
- **Complete?** Yes
- **Most Recent RUC Meeting:** January 2015
- **Tab:** 16
- **Specialty Developing Recommendation:** ASTRO
- **First Identified:** 2020
- **Medicare Utilization:** October 2014
- **RUC Recommendation:** Deleted from CPT
- **Referral:** Referred to CPT
- **Result:** Deleted from CPT
- **Published in CPT Asst:**

### 77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels
- **Global:** Surface Radionuclide High Does Rate Brachytherapy
- **Issue:** Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels
- **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure
- **Complete?** Yes
- **Most Recent RUC Meeting:** January 2015
- **Tab:** 16
- **Specialty Developing Recommendation:** ASTRO
- **First Identified:** October 2012
- **Medicare Utilization:** October 2014
- **RUC Recommendation:** Deleted from CPT
- **Referral:** Referred to CPT
- **Result:** Deleted from CPT
- **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
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### 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  

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#### 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  

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#### 78223 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

- **Global:** XXX  
- **Issue:** Hepatobiliary Ductal System Imaging  
- **Screen:** Harvard Valued - Utilization over 100,000  
- **Complete?** Yes  

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### Status Report: CMS Requests and Relativity Assessment Issues

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## 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);**

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### 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**

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### 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)**

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Tuesday, February 1, 2022

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### Cardiac Blood Pool Imaging

**Issue:** Cardiac Blood Pool Imaging

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

**Complete?** Yes

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| 2020 Medicare Utilization: | 13,479 |

| 2022 Work RVU: | 0.98 |
| 2022 NF PE RVU: | 5.42 |
| 2022 Fac PE RVU: | NA |

**Result:** Maintain

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst**

### Myocardial Perfusion Imaging

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

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**2020 Medicare Utilization:**

| 2022 Work RVU: | |
| 2022 NF PE RVU: | |
| 2022 Fac PE RVU: | |

**Result:** Deleted from CPT

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst**

### Myocardial Perfusion Imaging

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

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**2020 Medicare Utilization:**

| 2022 Work RVU: | |
| 2022 NF PE RVU: | |
| 2022 Fac PE RVU: | |

**Result:** Deleted from CPT

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst**
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<td>78579</td>
<td>Pulmonary ventilation imaging (e.g., aerosol or gas)</td>
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### Most Recent RUC Meeting:

- **78491**: January 2019
- **78492**: January 2019
- **78579**: February 2011

### Specialty Developing Recommendation:

- ACC, ACR, ACNM, SNMMI

### First Identified:

- May 2018
- October 2016
- February 2010

### Medicare Utilization:

- 501
- 137,725
- 294

### Result:

- Increase
- Increase
- Decrease

### Additional Notes:

- Referred to CPT
- Published in CPT Asst: Yes
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# Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>78815</td>
<td>Positron emission tomography (pet) with concurrently acquired computed tomography (ct) for attenuation correction and anatomical localization imaging; skull base to mid-thigh</td>
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Referred to CPT: No
Referred to CPT Asst: Yes
Published in CPT Asst: Yes
## Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 80506  Pathology clinical consultation; prolonged service, each additional 30 minutes

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**RUC Recommendation:** 0.80

- Referred to CPT: October 2020
- Published in CPT Asst: 

### 85060  Blood smear, peripheral, interpretation by physician with written report

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**RUC Recommendation:** 0.45

- Referred to CPT: 
- Published in CPT Asst: 

### 85097  Bone marrow, smear interpretation

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**RUC Recommendation:** 1.00

- Referred to CPT: 
- Published in CPT Asst: 

### 85390  Fibrinolysins or coagulopathy screen, interpretation and report

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**RUC Recommendation:** 0.75

- Referred to CPT: 
- Published in CPT Asst: 

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Tuesday, February 1, 2022
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<td>1.39</td>
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<tr>
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<td>Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation</td>
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<td>Yes</td>
<td>April 2015</td>
<td>36</td>
<td>AUR, ASC, CAP</td>
<td>February 2010</td>
<td>3,149</td>
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<td>17</td>
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<td>February 2010</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 88108  Cytopathology, concentration technique, smears and interpretation (eg, saccomanno technique)

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<th>Issue</th>
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<th>Most Recent</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>RUC Recommendation</th>
<th>First Identified</th>
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<th>referred to CPT</th>
<th>Referred to CPT Asst</th>
<th>Published in CPT Asst</th>
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</tbody>
</table>

### 88112  Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

<table>
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<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
<th>Most Recent</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>RUC Recommendation</th>
<th>First Identified</th>
<th>RUC Recommendation</th>
<th>referred to CPT</th>
<th>Referred to CPT Asst</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Cytopathology Concentration Technique-PE Only</td>
<td>CMS High Expenditure Procedural Codes1 / Final Rule for 2015</td>
<td>Yes</td>
<td>April 2015</td>
<td>36</td>
<td>ACR, CAP</td>
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</table>

### 88120  Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual

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Cytopathology, concentration technique, smears and interpretation (eg, saccomanno technique)
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<tr>
<td>88121</td>
<td>Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology</td>
<td>XXX</td>
<td>RAW review</td>
<td>CMS Request - Final Rule for 2013</td>
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| RUC Recommendation: | Utilization shift is appropriate. | Referred to CPT | Result: Maintain |

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<tr>
<th>Most Recent RUC Meeting:</th>
<th>October 2017</th>
<th>Tab: 19</th>
<th>Specialty Developing Recommendation:</th>
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<td>First Identified:</td>
<td>November 2012</td>
<td>2020</td>
<td>Medicare Utilization: 26,633</td>
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</table>

| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | XXX     | Cytopathology Cervical/Vaginal       | CMS-Other - Utilization over 30,000 | Yes       |

| RUC Recommendation: | 0.42 | Referred to CPT | Published in CPT Asst: |

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</table>

| 88160 | Cytopathology, smears, any other source; screening and interpretation | XXX     | Cytopathology Concentration Technique - PE Only | CMS Request - Final Rule for 2015 | Yes       |

| RUC Recommendation: | New PE Inputs | Referred to CPT | Published in CPT Asst: |

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<th>Most Recent RUC Meeting:</th>
<th>April 2015</th>
<th>Tab: 36</th>
<th>Specialty Developing Recommendation:</th>
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<td>First Identified:</td>
<td>April 2015</td>
<td>2020</td>
<td>Medicare Utilization: 6,189</td>
</tr>
</tbody>
</table>

| 2022 Work RVU: | 0.50  |

| 2022 NF PE RVU: | 0.38  |

| 2022 Fac PE RVU: | NA    |

### Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology

**Description:**

- **Global:** XXX
- **Issue:** RAW review
- **Screen:** CMS Request - Final Rule for 2013
- **Complete?** Yes

#### RUC Recommendation:

- Utilization shift is appropriate.
- Referred to CPT
- Published in CPT Asst: Yes

#### Additional Information:

- **Most Recent RUC Meeting:** October 2017
- **Tab:** 19
- **Specialty Developing Recommendation:**

#### Additional Details:

- **First Identified:** November 2012
- **2020 Medicare Utilization:** 26,633

---

**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

#### RUC Recommendation:

- 0.42
- Referred to CPT
- Published in CPT Asst: Yes

#### Additional Information:

- **Most Recent RUC Meeting:** April 2018
- **Tab:** 26
- **Specialty Developing Recommendation:** CAP

#### Additional Details:

- **First Identified:** October 2017
- **2020 Medicare Utilization:** 45,239

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**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

#### RUC Recommendation:

- New PE Inputs
- Referred to CPT
- Published in CPT Asst: Yes

#### Additional Information:

- **Most Recent RUC Meeting:** April 2015
- **Tab:** 36
- **Specialty Developing Recommendation:**

#### Additional Details:

- **First Identified:** April 2015
- **2020 Medicare Utilization:** 6,189

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### Additional Information

- **Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

- **Code:** 88121
- **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
- **2020 Medicare Utilization:** 26,633

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**Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

- **Code:** 88141
- **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
- **2020 Medicare Utilization:** 45,239

---

**Cytopathology, smears, any other source; screening and interpretation**

- **Code:** 88160
- **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
- **2020 Medicare Utilization:** 6,189

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**Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

- **Code:** 88121
- **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
- **2020 Medicare Utilization:** 26,633

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**Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

- **Code:** 88141
- **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
- **2020 Medicare Utilization:** 45,239

---

**Cytopathology, smears, any other source; screening and interpretation**

- **Code:** 88160
- **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
- **2020 Medicare Utilization:** 6,189
# Status Report: CMS Requests and Relativity Assessment Issues

## 88161 Cytopathology, smears, any other source; preparation, screening and interpretation

- **Global:** XXX  
- **Screen:** CMS Request - Final Rule for 2015
- **Complete?** Yes

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<th>Specialty Developing Recommendation: First Identified: April 2015</th>
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<tbody>
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<td>Medicare Utilization:</td>
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<td>Complete?</td>
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## 88162 Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains

- **Global:** XXX  
- **Screen:** CMS Request - Final Rule for 2015
- **Complete?** Yes

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<th>Tab: 36</th>
<th>Specialty Developing Recommendation: First Identified: April 2015</th>
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<td>Medicare Utilization:</td>
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## 88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker

- **Global:** XXX  
- **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018
- **Complete?** Yes

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<td>Medicare Utilization:</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Result</th>
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<th>Published in CPT Asst</th>
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</table>
## Status Report: CMS Requests and Relativity Assessment Issues

### Flow Cytometry Interpretation

**Flow Cytometry, interpretation; 16 or more markers**

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**Most Recent RUC Meeting:** January 2016  
**Specialty Developing Recommendation:** CAP  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 217,514  
**2022 Work RVU:** 1.70  
**2022 NF PE RVU:** 0.65  
**2022 Fac PE RVU:** 0.65

**RUC Recommendation:** 1.70  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

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### Surgical Pathology, Gross Examination Only

**Level i - surgical pathology, gross examination only**

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<td>Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012</td>
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**Most Recent RUC Meeting:** January 2012  
**Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 171,012  
**2022 Work RVU:** 0.08  
**2022 NF PE RVU:** 0.35  
**2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.08 and new PE inputs  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

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### Surgical Pathology, Gross and Microscopic Examination

**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**

<table>
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<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
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**Most Recent RUC Meeting:** January 2012  
**Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 59,362  
**2022 Work RVU:** 0.13  
**2022 NF PE RVU:** 0.78  
**2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.13 and new PE inputs  
**Referred to CPT**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

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**Status Report: CMS Requests and Relativity Assessment Issues**

| 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 |

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<td></td>
<td>Published in CPT Asst:</td>
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<td>Result: Maintain</td>
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**Note:** This document is a status report on CMS requests and relativity assessment issues, focusing on pathology consultations. It includes details on the level of pathology consultations, global issue, and specific procedures under level III, along with relevant data on Medicare utilization and RVUs for the year 2022.
### 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, transbrachial 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**

<table>
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<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012</td>
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<tr>
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<th>Specialty Developing Recommendation: AAD, AGA, CAP, ASGE</th>
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<table>
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<th>0.75 and new PE inputs</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 88307

**Global:** XXX  
**Issue:** Pathology Consultations  
**Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012  
**Complete?** Yes

**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**

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### 88309

**Global:** XXX  
**Issue:** Pathology Services  
**Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012  
**Complete?** Yes

**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**

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## Status Report: CMS Requests and Relativity Assessment Issues

### 88312
Special stain including interpretation and report; group i for microorganisms (eg, acid fast, methenamine silver)

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### 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

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### 88314
Special stain including interpretation and report; histochemical stain on frozen tissue block (list separately in addition to code for primary procedure)

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**Status Report: CMS Requests and Relativity Assessment Issues**

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### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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| **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) | |
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| Tab: 21 | Specialty Developing Recommendation: CAP | First Identified: November 2013 | 2020 Medicare Utilization: |
| RUC Recommendation: Deleted from CPT | Referred to CPT | | Referred to CPT Asst | Published in CPT Asst: |
| Referred to CPT | Result: Deleted from CPT | |

| **88344** Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure | |
| Most Recent RUC Meeting: April 2014 | |
| RUC Recommendation: 0.77 | Referred to CPT | | Referred to CPT Asst | Published in CPT Asst: |
| Referred to CPT | Result: Decrease | |

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**Notes:**
- **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
- **2022 Work RVU:** 0.70
- **2022 NF PE RVU:** 2.24
- **2022 Fac PE RVU:** NA

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## Status Report: CMS Requests and Relativity Assessment Issues

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| 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 | XXX    | Tumor Immunohistochemistry | CMS High Expenditure Procedural Codes2 | Yes       |
|        | Most Recent RUC Meeting: April 2016                                          |        | First Identified: July 2015 | 2020 Medicare Utilization: 149,962      |           |
|        | Tab: 40                         Specialty Developing Recommendation: ASC, CAP |        |                         | 2022 Work RVU: 0.95                     |           |
|        | RUC Recommendation: 0.95                                                   |        |                         | 2022 NF PE RVU: 2.56                    |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                         | 2022 Fac PE RVU: NA                     |           |
|        | Result: Decrease                                                            |        |                         |                                         |           |

| 88364  | In situ hybridization (eg, fish), per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure) | ZZZ    | Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) | CMS Request - Final Rule for 2014 | Yes       |
|        | Most Recent RUC Meeting: April 2014                                          |        | First Identified: November 2013 | 2020 Medicare Utilization: 30,654      |           |
|        | Tab: 21                         Specialty Developing Recommendation: CAP, ASCP, ASC |        |                         | 2022 Work RVU: 0.70                    |           |
|        | RUC Recommendation: 0.88                                                   |        |                         | 2022 NF PE RVU: 3.33                   |           |
|        | Referred to CPT Asst Published in CPT Asst:                                 |        |                         | 2022 Fac PE RVU: NA                     |           |
|        | Result: Decrease                                                            |        |                         |                                         |           |
# Status Report: CMS Requests and Relativity Assessment Issues

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<td>88373</td>
<td>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)</td>
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<td>Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)</td>
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<td>88374</td>
<td>Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure</td>
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**Most Recent RUC Meeting:**
- September 2014
- April 2014
- April 2014

**Screening:**
- 2020 Medicare Utilization:
  - 88368: 17,558
  - 88373: 5,451
  - 88374: 125,957

**Other Details:**
- Referred to CPT Asst: Published in CPT Asst: May 2013, Dec 2011 & May 2012
## 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

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### 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

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### 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)

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<td>90473</td>
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<tr>
<td>90474</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Psychotherapy for Crisis and Interactive Complexity</td>
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<td>90791 Psychiatric diagnostic evaluation</td>
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<td>90792 Psychiatric diagnostic evaluation with medical services</td>
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#### Most Recent RUC Meeting:
- **January 2020**

#### Tab: 37
- Specialty Developing Recommendation: APA, APA (HCPAC), NASW

#### First Identified: April 2013

#### Screen: CMS High Expenditure Procedural Codes1 / High Volume Growth6

#### 2022 Work RVU: 0.33

#### 2022 NF PE RVU: 0.09

#### 2022 Fac PE RVU: 0.04

#### Referred to CPT: October 2020

#### Referred to CPT Asst: Published in CPT Asst:

#### Result: Increase

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#### Most Recent RUC Meeting:
- **April 2012**

#### Tab: 26
- Specialty Developing Recommendation: APA, APA (HCPAC), NASW

#### First Identified: April 2013

#### Screen: CMS High Expenditure Procedural Codes1

#### 2022 Work RVU: 3.84

#### 2022 NF PE RVU: 1.21

#### 2022 Fac PE RVU: 0.49

#### Referred to CPT: February 2012

#### Referred to CPT Asst: Published in CPT Asst:

#### Result: Increase

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#### Most Recent RUC Meeting:
- **April 2012**

#### Tab: 26
- Specialty Developing Recommendation: APA, APA (HCPAC), NASW

#### First Identified: April 2013

#### Screen: CMS High Expenditure Procedural Codes1

#### 2022 Work RVU: 4.16

#### 2022 NF PE RVU: 1.46

#### 2022 Fac PE RVU: 0.75

#### Referred to CPT: February 2012

#### Referred to CPT Asst: Published in CPT Asst:

#### Result: Increase

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>90805</td>
<td>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</td>
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## 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:**

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**Most Recent RUC Meeting:** January 2012  
**Tab:** 30  
**Specialty Developing Recommendation:**

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**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** February 2012  
**Referred to CPT Asst:**

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

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### 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:**

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**Most Recent RUC Meeting:** January 2012  
**Tab:** 30  
**Specialty Developing Recommendation:**

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**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** February 2012  
**Referred to CPT Asst:**

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

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### 90832

**Psychotherapy, 30 minutes with patient**

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**Most Recent RUC Meeting:** April 2012  
**Tab:** 26  
**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

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**RUC Recommendation:** 1.50  
**Referred to CPT:** February 2012  
**Referred to CPT Asst:**

**Result:** Increase  
**Published in CPT Asst:**

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## Status Report: CMS Requests and Relativity Assessment Issues

| CMS Code | Description                                                                 | Global | Issue       | Screen             | Complete?
|----------|-------------------------------------------------------------------------------|--------|-------------|--------------------|----------------
| 90833    | Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure) | ZZZ    | Psychotherapy | CMS High Expenditure Procedural Codes | Yes
|          | Most Recent RUC Meeting: April 2012                                            |        |             |                   |                
|          | Tab: 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW          |        |             |                   |                
|          | First Identified: April 2013                                                   |        |             |                   |                
|          | 2020 Medicare Utilization: 1,363,088                                           |        |             |                   |                
|          | 2022 Work RVU: 1.50                                                            |        |             |                   |                
|          | 2022 NF PE RVU: 0.49                                                           |        |             |                   |                
|          | 2022 Fac PE RVU: 0.27                                                          |        |             |                   |                
|          | RUC Recommendation: 1.50                                                        |        |             |                   |                
|          | Referred to CPT                   February 2012                                 |        |             |                   |                
|          | Referred to CPT Asst               Published in CPT Asst:                      |        |             |                   |                
|          | Referral to CPT                   February 2012                                 |        |             |                   |                
|          | Referred to CPT Asst               Published in CPT Asst:                      |        |             |                   |                

| 90834    | Psychotherapy, 45 minutes with patient                                        | XXX    | Psychotherapy | CMS High Expenditure Procedural Codes | Yes
|          | Most Recent RUC Meeting: April 2012                                            |        |             |                   |                
|          | Tab: 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW          |        |             |                   |                
|          | First Identified: April 2013                                                   |        |             |                   |                
|          | 2020 Medicare Utilization: 4,442,413                                           |        |             |                   |                
|          | 2022 Work RVU: 2.24                                                            |        |             |                   |                
|          | 2022 NF PE RVU: 0.64                                                           |        |             |                   |                
|          | 2022 Fac PE RVU: 0.29                                                          |        |             |                   |                
|          | RUC Recommendation: 2.00                                                        |        |             |                   |                
|          | Referred to CPT                   February 2012                                 |        |             |                   |                
|          | 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) | ZZZ    | Psychotherapy | CMS High Expenditure Procedural Codes | Yes
|          | Most Recent RUC Meeting: April 2012                                            |        |             |                   |                
|          | Tab: 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW          |        |             |                   |                
|          | First Identified: April 2013                                                   |        |             |                   |                
|          | 2020 Medicare Utilization: 483,506                                             |        |             |                   |                
|          | 2022 Work RVU: 1.90                                                            |        |             |                   |                
|          | 2022 NF PE RVU: 0.62                                                           |        |             |                   |                
|          | 2022 Fac PE RVU: 0.34                                                          |        |             |                   |                
|          | RUC Recommendation: 1.90                                                        |        |             |                   |                
|          | Referred to CPT                   February 2012                                 |        |             |                   |                
|          | Referred to CPT Asst               Published in CPT Asst:                      |        |             |                   |                

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Tuesday, February 1, 2022

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## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Global</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
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<tr>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<td>CMS High Expenditure Procedural Codes</td>
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### 90837

**Psychotherapy, 60 minutes with patient**

| Most Recent RUC Meeting: | April 2012 |
| Tab: | 26 |
| Specialty Developing Recommendation: | APA, APA (HCPAC), NASW |
| First Identified: | April 2013 |
| 2020 Medicare Utilization: | 6,129,662 |
| RUC Recommendation: | 3.00 |
| Referred to CPT: | February 2012 |
| Complete? | Yes |

### 90838

**Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)**

| Most Recent RUC Meeting: | April 2012 |
| Tab: | 26 |
| Specialty Developing Recommendation: | APA, APA (HCPAC), NASW |
| First Identified: | April 2013 |
| 2020 Medicare Utilization: | 100,291 |
| RUC Recommendation: | 2.50 |
| Referred to CPT: | February 2012 |
| Complete? | Yes |

### 90839

**Psychotherapy for crisis; first 60 minutes**

<p>| Most Recent RUC Meeting: | April 2013 |
| Tab: | 35 |
| Specialty Developing Recommendation: | APA, APA (HCPAC), NASW |
| First Identified: | April 2013 |
| 2020 Medicare Utilization: | 25,447 |
| RUC Recommendation: | 3.13 |
| Referred to CPT: | February 2012 |
| Complete? | Yes |</p>
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<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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<tbody>
<tr>
<td><strong>90840</strong> Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)</td>
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<tr>
<td>Most Recent RUC Meeting: April 2013</td>
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<tr>
<td>Issue: Psychotherapy for Crisis and Interactive Complexity</td>
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<tr>
<td>2020 Medicare Utilization: 16,948</td>
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<td>Result: Increase</td>
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<td>Published in CPT Asst: Yes</td>
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<tr>
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| **90845** Psychoanalysis |
| Most Recent RUC Meeting: October 2011 |
| Specialty Developing Recommendation: |
| First Identified: April 2013 |
| Global: XXX |
| Issue: Psychotherapy |
| Screen: CMS High Expenditure Procedural Codes1 |
| Complete? Yes |
| 2020 Medicare Utilization: 9,732 |
| Result: Increase |
| Referred to CPT Asst: Yes |
| Published in CPT Asst: Yes |
| Referred to CPT: February 2012 |

| **90846** Family psychotherapy (without the patient present), 50 minutes |
| Most Recent RUC Meeting: April 2012 |
| Specialty Developing Recommendation: APA, APA (HCPAC), NASW |
| First Identified: April 2013 |
| Global: XXX |
| Issue: Psychotherapy |
| Screen: CMS High Expenditure Procedural Codes1 |
| Complete? Yes |
| 2020 Medicare Utilization: 25,927 |
| Result: Increase |
| Referred to CPT Asst: Yes |
| Published in CPT Asst: Yes |
| Referred to CPT: February 2012 |

| **90847** Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes |
| Most Recent RUC Meeting: April 2012 |
| Specialty Developing Recommendation: APA, APA (HCPAC), NASW |
| First Identified: April 2013 |
| Global: XXX |
| Issue: Psychotherapy |
| Screen: CMS High Expenditure Procedural Codes1 |
| Complete? Yes |
| 2020 Medicare Utilization: 147,608 |
| Result: Increase |
| Referred to CPT Asst: Yes |
| Published in CPT Asst: Yes |
| Referred to CPT: February 2012 |
**Status Report: CMS Requests and Relativity Assessment Issues**

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<th>Group psychotherapy (other than of a multiple-family group)</th>
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<th>Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy</th>
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<td>Issue: RAW review</td>
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<td>2022 Fac PE RVU: 0.08</td>
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**Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)**

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### Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session

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<td>Contractor Priced High Volume</td>
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**Most Recent RUC Meeting:** October 2020  
**Tab:** 23  
**Specialty Developing Recommendation:**

**First Identified:** January 2018  
**2020 Medicare Utilization:** 195,379  
**RUC Recommendation:** Review in 2 years (Oct 2023)

**Referral Details:**
- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst:

### Electroconvulsive therapy (includes necessary monitoring)

<table>
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<th>Complete?</th>
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<td>Electroconvulsive Therapy</td>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 41  
**Specialty Developing Recommendation:** APA

**First Identified:** October 2009  
**2020 Medicare Utilization:** 96,127  
**RUC Recommendation:** 2.50

**Result:** Increase

**Referral Details:**
- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst:

### Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

<table>
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<th>Screen</th>
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<tbody>
<tr>
<td>000</td>
<td>Biofeedback Training</td>
<td>Yes</td>
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**Most Recent RUC Meeting:** January 2019  
**Tab:** 15  
**Specialty Developing Recommendation:** ACOG, AUA

**First Identified:** April 2017  
**2020 Medicare Utilization:** 2022 Work RVU: 0.90  
**RUC Recommendation:** Deleted from CPT

**Result:** Deleted from CPT

**Referral Details:**
- Referred to CPT
- Referred to CPT Asst
- Published in CPT Asst:

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### 90913 Biofeedback Training

- **Issue:** Biofeedback Training
- **Screen:** Negative IWPUT
- **Complete?** Yes
- **First Identified:** September 2018
- **Medicare Utilization:** 10,692
- **RUC Recommendation:** 0.50
- **Referred to CPT**
- **February 2019-EC**
- **Result:** Increase
- **Published in CPT Asst:**

#### Most Recent RUC Meeting:
- **Tab:** 15
- **Specialty Developing Recommendation:**

#### Global:
- **000**

#### Issue:
- **Biofeedback Training**

#### Screen:
- **Negative IWPUT**

#### Complete?
- **Yes**

#### RUC Recommendation:
- **0.50**

#### Referred to CPT Asst Published in CPT Asst:
- **No**

### 90935 Hemodialysis procedure with single evaluation by a physician or other qualified health care professional

- **Issue:** Hemodialysis-Dialysis Services
- **Screen:** Havard Valued - Utilization over 1 Million
- **Complete?** Yes
- **First Identified:** October 2008
- **Medicare Utilization:** 955,376
- **RUC Recommendation:** 1.48
- **Referred to CPT**
- **Published in CPT Asst:**

#### Most Recent RUC Meeting:
- **Tab:** 30
- **Specialty Developing Recommendation:** RPA

#### Global:
- **000**

#### Issue:
- **Hemodialysis-Dialysis Services**

#### Screen:
- **Havard Valued - Utilization over 1 Million**

#### Complete?
- **Yes**

#### RUC Recommendation:
- **1.48**

#### Referred to CPT Asst Published in CPT Asst:
- **No**

### 90937 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

- **Issue:** Hemodialysis-Dialysis Services
- **Screen:** Havard Valued - Utilization over 1 Million
- **Complete?** Yes
- **First Identified:** February 2009
- **Medicare Utilization:** 45,670
- **RUC Recommendation:** 2.11
- **Referred to CPT**
- **Published in CPT Asst:**

#### Most Recent RUC Meeting:
- **Tab:** 30
- **Specialty Developing Recommendation:** RPA

#### Global:
- **000**

#### Issue:
- **Hemodialysis-Dialysis Services**

#### Screen:
- **Havard Valued - Utilization over 1 Million**

#### Complete?
- **Yes**

#### RUC Recommendation:
- **2.11**

#### Referred to CPT Asst Published in CPT Asst:
- **No**

#### Result:
- **Maintain**
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>90945</td>
<td>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</td>
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<td>Hemodialysis-Dialysis Services</td>
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|        | **Result:** Increase                                                                                                                         |        | **Referral:** 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 | 000    | Hemodialysis-Dialysis Services | Havard Valued - Utilization over 1 Million | Yes       |
|        | **Most Recent RUC Meeting:** October 2009                                                                                                    | 000    | **Issue:** Hemodialysis-Dialysis Services |               |           |
|        | **Tab:** 30                                                                                                                                  | 2020   | **Medicare Utilization:** 13,348 |               |           |
|        | **Specialty Developing Recommendation:** RPA                                                                                                 |        | **2022 Work RVU:** 2.52 |               |           |
|        | **First Identified:** February 2009                                                                                                         |        | **2022 NF PE RVU:** NA |               |           |
|        | **RUC Recommendation:** 2.52                                                                                                                 |        | **2022 Fac PE RVU:** 0.93 |               |           |

|        | **Result:** Increase                                                                                                                         |        | **Referral:** CPT Asst Published in CPT Asst: |           |

| 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 | XXX    | End-Stage Renal Disease          | CMS Request - Practice Expense Review | Yes       |
|        | **Most Recent RUC Meeting:** April 2009                                                                                                       |        | **Issue:** End-Stage Renal Disease |               |           |
|        | **Tab:** 29                                                                                                                                  |        | **Screen:** CMS Request - Practice Expense Review |               |           |
|        | **Specialty Developing Recommendation:** RPA                                                                                                 |        | **Complete?** Yes |               |           |
|        | **First Identified:** February 2009                                                                                                         |        | **2020 Medicare Utilization:** 14 |               |           |
|        | **RUC Recommendation:** RUC Recommended revised clinical staff time                                                                         |        | **2022 Work RVU:** 23.92 |               |           |
|        |                                                                                                                                             |        | **2022 NF PE RVU:** 9.21 |               |           |
|        | **Referral:** CPT Asst Published in CPT Asst:                                                                                                 |        | **2022 Fac PE RVU:** 9.21 |               |           |

**Result:** PE Only
### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Description</th>
<th>Global</th>
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<td>90952</td>
<td>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</td>
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<td>End-Stage Renal Disease</td>
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| 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 | XXX    | End-Stage Renal Disease     | Screen: CMS Request - Practice Expense Review | Yes          |
|               | Most Recent RUC Meeting: April 2009                                            |        |      | First Identified: February 2009                                       | RUC Recommended revised clinical staff time                             |           |
|               | Tab: 29 Specialty Developing Recommendation: RPA                               |        |      | 2020 Medicare Utilization: 2                                           | Result: PE Only                                                       |           |
|               | 2022 Work RVU: 0.00                                                           |        |      | 2022 NF PE RVU: 0.00                                                  |                                                                         |           |
|               | 2022 Fac PE RVU: 0.00                                                          |        |      | RUC Recommendation: RUC Recommended revised clinical staff time       |                                                                         |           |
|               | Refer to CPT                                                                  |        |      | Refer to CPT Asst                                                      |                                                                         |           |
|               | Published in CPT Asst                                                         |        |      |                                                                         |                                                                         |           |

| 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 | XXX    | End-Stage Renal Disease     | Screen: CMS Request - Practice Expense Review | Yes          |
|               | Most Recent RUC Meeting: April 2009                                            |        |      | First Identified: February 2009                                       | RUC Recommended revised clinical staff time                             |           |
|               | 2022 Work RVU: 20.86                                                          |        |      | 2022 NF PE RVU: 7.62                                                 |                                                                         |           |
|               | 2022 Fac PE RVU: 7.62                                                          |        |      | RUC Recommendation: RUC Recommended revised clinical staff time       |                                                                         |           |
|               | Refer to CPT                                                                  |        |      | Refer to CPT Asst                                                      |                                                                         |           |
|               | Published in CPT Asst                                                         |        |      |                                                                         |                                                                         |           |
### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

| Code | Description | Global | Issue | Screen | Complete? | Most Recent | RUC Meeting | Tab | Specialty Developing Recommendation | First Identified | 2020 Medicare Utilization | 2022 Work RVU | 2022 NF PE RVU | 2022 Fac PE RVU |
|------|-------------|--------|-------|--------|----------|-------------|-------------|-----|-------------------------------------|-----------------|-----------------------|----------------|--------------|----------------|----------------|
| 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 | XXX | End-Stage Renal Disease | CMS Request - Practice Expense Review | Yes | April 2009 | RPA | 29 | RUC Recommended revised physician and clinical staff time | February 2009 | 667,595 | 5.52 | 2.80 | 2.80 |
| 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 | XXX | End-Stage Renal Disease | CMS Request - Practice Expense Review | Yes | April 2009 | RPA | 29 | RUC Recommended revised clinical staff time | February 2009 | 198,834 | 3.57 | 2.16 | 2.16 |
| 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 | XXX | End-Stage Renal Disease | CMS Request - Practice Expense Review | Yes | April 2009 | RPA | 29 | RUC Recommended revised clinical staff time | February 2009 | 189 | 12.09 | 5.06 | 5.06 |
### Status Report: CMS Requests and Relativity Assessment Issues

**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  

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**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  

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**90966**  
End-stage renal disease (esrd) related services for home dialysis per full month, for patients 20 years of age and older  

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**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  
- **2020 Medicare Utilization:** 960  
- **2022 Work RVU:** 10.25  
- **2022 NF PE RVU:** 4.47  
- **2022 Fac PE RVU:** 4.47  

**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  
- **2020 Medicare Utilization:** 1,411  
- **2022 Work RVU:** 9.80  
- **2022 NF PE RVU:** 4.35  
- **2022 Fac PE RVU:** 4.35  

**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  
- **2020 Medicare Utilization:** 393,883  
- **2022 Work RVU:** 5.52  
- **2022 NF PE RVU:** 2.80  
- **2022 Fac PE RVU:** 2.80
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>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)</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 91132  Electrogastrography, diagnostic, transcutaneous;

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### 91133  Electrogastrography, diagnostic, transcutaneous; with provocative testing

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### 92065  Orthoptic training

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<td>92081</td>
<td>Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, autoplott, arc perimeter, or single stimulus level automated test, such as octopus 3 or 7 equivalent)</td>
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<td>Visual Field Examination</td>
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<td>42</td>
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<td>92082</td>
<td>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)</td>
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<td>October 2009</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

**920XX**

**Issue:** Orthoptic Training

- **Global:** New PE Inputs
- **Screen:** Harvard Valued - Utilization over 30,000-Part4
- **Complete?** Yes
- **First Identified:** February 2021
- **Medicare Utilization:** 2020
- **Result:** PE Only

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**92100**

**Issue:** Serial Tonometry

- **Global:** XXX
- **Screen:** Harvard Valued - Utilization over 30,000
- **Complete?** Yes
- **First Identified:** April 2011
- **Medicare Utilization:** 2020
- **Result:** Decrease

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**92133**

**Issue:** Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

- **Global:** XXX
- **Screen:** CMS Fastest Growing
- **Complete?** Yes
- **First Identified:** October 2009
- **Medicare Utilization:** 2020
- **Result:** Decrease

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# Status Report: CMS Requests and Relativity Assessment Issues

## 92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

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- Referred to CPT: October 2009
- Published in CPT Asst: 

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- Referred to CPT: October 2009
- Published in CPT Asst: 

## 92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation

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Tuesday, February 1, 2022
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral</td>
<td>XXX</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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### Status Report: CMS Requests and Relativity Assessment Issues

#### 92275 Electroretinography with interpretation and report

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<td>Electroretinography</td>
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**Most Recent RUC Meeting:** January 2018  
**Tab:** 17  
**Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry)  
**First Identified:** July 2015  
**2020 Medicare Utilization:**  

- **2022 Work RVU:**  
- **2022 NF PE RVU:**  
- **2022 Fac PE RVU:**  

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

#### 92284 Dark adaptation examination with interpretation and report

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<td>Dark Adaption Eye Exam</td>
<td>Harvard Valued - Utilization over 30,000-Part5</td>
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**Most Recent RUC Meeting:** April 2021  
**Tab:** 20  
**Specialty Developing Recommendation:** AAO, AOA (optometry), ASRS  
**First Identified:** October 2020  
**2020 Medicare Utilization:** 28,131  

- **2022 Work RVU:** 0.24  
- **2022 NF PE RVU:** 1.43  
- **2022 Fac PE RVU:** NA  

**RUC Recommendation:** 0.14. Review Technology  
**Referred to CPT:** May 2021  
**Published in CPT Asst:**  
**Result:** Decrease

#### 92285 External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)

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<td>Ocular Photography</td>
<td>CMS Fastest Growing. Harvard Valued - Utilization over 100,000</td>
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**Most Recent RUC Meeting:** October 2009  
**Tab:** 32  
**Specialty Developing Recommendation:** AAO, AOA  
**First Identified:** October 2008  
**2020 Medicare Utilization:** 329,781  

- **2022 Work RVU:** 0.05  
- **2022 NF PE RVU:** 0.61  
- **2022 Fac PE RVU:** NA  

**RUC Recommendation:** 0.05 and new PE inputs  
**Referred to CPT:** February 2010  
**Published in CPT Asst:**  
**Result:** Decrease
## Status Report: CMS Requests and Relativity Assessment Issues

### 92286 Anterior Segment Imaging

- **Global**: XXX
- **Issue**: Anterior Segment Imaging
- **Screen**: Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million
- **Complete?**: Yes

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### 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

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### 92504 Binocular Microscopy (Separate Diagnostic Procedure)

- **Global**: XXX
- **Issue**: Binocular Microscopy
- **Screen**: Harvard Valued - Utilization over 100,000
- **Complete?**: Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

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| 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 |
|         | RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen. |        | Referred to CPT                                                   | Result: Decrease                     |           |

| 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:                           | 2020 Medicare Utilization: 1,932 | 2022 Work RVU: 0.33 | 2022 NF PE RVU: 0.36 | 2022 Fac PE RVU: NA |
|         | RUC Recommendation: 0.43 work RVU and clinical staff time removed              |        | Referred to CPT                                                   | Result: Decrease                     |           |
# Status Report: CMS Requests and Relativity Assessment Issues

## 92521 Evaluation of speech fluency (eg, stuttering, cluttering)

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## 92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);

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</table>

## 92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)

<table>
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<th>Issue: Speech Evaluation</th>
<th>Screen: CMS Request/Speech Language Pathology Request</th>
<th>Complete? Yes</th>
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<td>Tab: 32</td>
<td>Specialty Developing Recommendation: ASHA</td>
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<td>2022 Work RVU: 3.84</td>
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<td>Global</td>
<td>Issue</td>
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<tr>
<td>92524</td>
<td>XXX</td>
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<td>92526</td>
<td>XXX</td>
<td>Speech Language Pathology Services (HCPAC)</td>
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<tr>
<td>92537</td>
<td>XXX</td>
<td>Vestibular Caloric Irrigation</td>
<td>CMS-Other - Utilization over 250,000</td>
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### Behavioral and qualitative analysis of voice and resonance

**RUC Meeting:** January 2013  
**Tab:** 32  
**Specialty Developing Recommendation:** ASHA  
**First Identified:** 2020  
**Medicare Utilization:** 13,510  
**Complete?** Yes  
**Result:** Increase  
**Referral:** Referred to CPT

### Treatment of swallowing dysfunction and/or oral function for feeding

**RUC Meeting:** October 2020  
**Tab:** 23  
**Specialty Developing Recommendation:** ASHA, AAO-HNS  
**First Identified:** NA  
**Medicare Utilization:** 121,719  
**Complete?** Yes  
**Result:** Decrease  
**Referral:** Referred to CPT

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

**RUC Meeting:** January 2015  
**Tab:** 18  
**Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA  
**First Identified:** October 2014  
**Medicare Utilization:** 49,240  
**Complete?** Yes  
**Result:** Increase  
**Referral:** Referred to CPT
## Status Report: CMS Requests and Relativity Assessment Issues

### 92538  
Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)

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<td>Referred to CPT Asst Published in CPT Asst:</td>
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### 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

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<th>Global: XXX</th>
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<td>Referred to CPT Asst Published in CPT Asst:</td>
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### 92541  
Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>AAN, ASHA, AAH-HNS, AAA</td>
<td>February 2008</td>
<td>2,100</td>
<td>Increase</td>
<td>Referred to CPT</td>
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**Notes:**
- Positional nystagmus test, minimum of 4 positions, with recording
- Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording
- Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
<table>
<thead>
<tr>
<th>Code</th>
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<td>92546</td>
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<tr>
<td>92547</td>
<td>Use of vertical electrodes (list separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
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<td>Published in CPT Asst</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>CPT Code</th>
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<th>Result</th>
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<tr>
<td>92548</td>
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<td>Computerized Dynamic Posturography</td>
<td>CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey</td>
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<td>September 2018 / February 2014</td>
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<td>CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey</td>
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<tr>
<td>92550</td>
<td>Tympanometry and reflex threshold measurements</td>
<td>XXX</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

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#### 92558 Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

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#### 92567 Tympanometry (impedance testing)

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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>Acoustic immittance testing, includes tympanometry (impedance testing),</td>
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<td>acoustic reflex threshold testing, and acoustic reflex decay testing</td>
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<td>92584</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 92585 Auditory Evoked Potentials

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### 92586 Auditory Evoked Potentials

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### 92587 Distortion Product Evoked Otoacoustic Emissions

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### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 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

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### 92620 Evaluation of central auditory function, with report; initial 60 minutes

- **Global:** XXX
- **Issue:** Audiology Services
- **Screen:** CMS Request - Audiology Services
- **Complete?** Yes

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### 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

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<td>92625</td>
<td>Assessment of tinnitus (includes pitch, loudness matching, and masking)</td>
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Referred to CPT: | February 2019 | Referred to CPT Asst: | Published in CPT Asst: |

Result: Increase

Referred to CPT: | October 2011 | Referred to CPT Asst: | Published in CPT Asst: |

Result: Decrease

Referred to CPT: | October 2011 | Referred to CPT Asst: | Published in CPT Asst: |

Result: Decrease
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*Tuesday, February 1, 2022*
### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

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### Cardiovascular Stress Tests

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## Status Report: CMS Requests and Relativity Assessment Issues

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| **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                          |
| **2020 Medicare Utilization:**                              |
| **2022 Work RVU:**                                          |
| **2022 NF PE RVU:**                                         |
| **2022 Fac PE RVU:**                                        |
| **Referral to CPT:** February 2010                          |
| **Referral to CPT Asst Published in CPT Asst:**             |
| **Result:** Deleted from CPT                                |

<p>| <strong>93236</strong> Deleted from CPT                                  |
| <strong>Global:</strong>                                                 |
| <strong>Issue:</strong> Cardiovascular Stress Test                       |
| <strong>Screen:</strong> Harvard Valued - Utilization over 100,000        |
| <strong>Complete?</strong> Yes                                           |
| <strong>Most Recent RUC Meeting:</strong> April 2009                      |
| <strong>Tab:</strong> 38                                                 |
| <strong>Specialty Developing Recommendation:</strong> ACC                 |
| <strong>First Identified:</strong> February 2008                         |
| <strong>2020 Medicare Utilization:</strong>                              |
| <strong>2022 Work RVU:</strong>                                          |
| <strong>2022 NF PE RVU:</strong>                                         |
| <strong>2022 Fac PE RVU:</strong>                                        |
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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.

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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).

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<td><strong>February 2010</strong></td>
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<td><strong>Result:</strong> PE Only</td>
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Tuesday, February 1, 2022 Page 663 of 836
<p>| Code   | Description                                                                 | Global | Issue                                      | Screen                                      | Complete? | Most Recent RUC Meeting | Tab | Specialty Developing Recommendation | First Identified | 2020 Medicare Utilization | 2022 Work RVU | 2022 NF PE RVU | 2022 Fac PE RVU | Result       |
|--------|-------------------------------|--------|-------------------------------------------|---------------------------------------------|----------|------------------------|-----|------------------------|-----------------|------------------------|----------------|----------------|----------------|----------------|----------------|
| 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 | XXX    | External Cardiovascular Device Monitoring | Harvard Valued - Utilization over 100,000 | Yes      | April 2010             | 25  | ACC                    | October 2009    | 45,016                  | 0.00           | 4.49          | NA             | PE Only       |
|        |                               |        |                                           |                                             |          |                        |     |                        |                 |                         |                |               |                |               |
| 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 | XXX    | External Cardiovascular Device Monitoring | Harvard Valued - Utilization over 100,000 | Yes      | April 2010             | 25  | ACC                    | October 2009    | 92,987                  | 0.52           | 0.18          | 0.18           | Maintain      |
|        |                               |        |                                           |                                             |          |                        |     |                        |                 |                         |                |               |                |               |
| 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 | XXX    | Cardiac Electrophysiology Device Monitoring Services | CMS High Expenditure Procedural Codes2 | Yes      | October 2016           | 25  | ACC, HRS               | July 2015        | 107,697                 | 0.65           | 1.37          | NA             | Maintain      |
|        |                               |        |                                           |                                             |          |                        |     |                        |                 |                         |                |               |                |               |</p>
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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

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Referred to CPT February 2017  Result: Maintain

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

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Referred to CPT February 2017  Result: Maintain

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

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Referred to CPT February 2017  Result: Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>single, dual, or multiple lead pacemaker system, or leadless pacemaker system</td>
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<td>93287</td>
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<td>single, dual, or multiple lead implantable defibrillator system</td>
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<td>Interrogation device evaluation (in person) with analysis, review and report by</td>
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<td>a physician or other qualified health care professional, includes connection,</td>
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<td>recording and disconnection per patient encounter; single, dual, or multiple lead</td>
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<td>pacemaker system, or leadless pacemaker system</td>
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<td>93289</td>
<td>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</td>
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<td>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</td>
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<td>93291</td>
<td>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</td>
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<td>93292</td>
<td>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</td>
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<td>ACC, HRS</td>
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<td>93293</td>
<td>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</td>
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<td>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</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>93296</td>
<td>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</td>
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<td>CMS High Expenditure Procedural Codes²</td>
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<td>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</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>93298</td>
<td>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</td>
<td>XXX</td>
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<td>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</td>
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<td>CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume</td>
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<td>93306</td>
<td>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</td>
<td>XXX</td>
<td>Complete Transthoracic Echocardiography (TTE) with Doppler</td>
<td>CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2019</td>
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### Most Recent RUC Meeting

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<th>Tab</th>
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<td>23</td>
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<td>884,510</td>
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<td>21</td>
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### Published in CPT Asst

- 93298: October 2018
- 93299: February 2019
- 93306: April 2019

### Result

- Maintain
- Deleted from CPT
- Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2</td>
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<td>437,576</td>
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<td>Doppler Echocardiography</td>
<td>CMS-Other - Utilization over 250,000</td>
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**Most Recent RUC Meeting:** January 2014  
**Tab:** 30  
**Specialty Developing Recommendation:** ACC  
**First Identified:** October 2013  
**2020 Medicare Utilization:** 232,010  
**2022 Work RVU:** 0.15  
**2022 NF PE RVU:** 0.60  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.15  
**Result:** Maintain

Refer to CPT

### 93325

**Doppler echocardiography color flow velocity mapping (list separately in addition to codes for echocardiography)**

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<td>Doppler Echocardiography</td>
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**Most Recent RUC Meeting:** January 2014  
**Tab:** 30  
**Specialty Developing Recommendation:** ACC  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 522,631  
**2022 Work RVU:** 0.07  
**2022 NF PE RVU:** 0.64  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.07  
**Result:** Maintain

Refer to CPT

### 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;**

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<th>Issue</th>
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<td>XXX</td>
<td>Stress Transthoracic Echocardiography (TTE) Complete</td>
<td>Other - Identified by RUC / Codes Reported Together 75% or More-Part1</td>
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**Most Recent RUC Meeting:** October 2016  
**Tab:** 26  
**Specialty Developing Recommendation:** ACC, ASE  
**First Identified:** April 2008  
**2020 Medicare Utilization:** 69,260  
**2022 Work RVU:** 1.46  
**2022 NF PE RVU:** 4.09  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 1.46; CPT Assistant article published  
**Result:** Decrease

Refer to CPT

Refer to CPT Asst  
Published in CPT Asst: Jan 2010
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>93351</td>
<td>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 pharmacoologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional</td>
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<td>Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed</td>
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<td>Diagnostic Cardiac Catheterization</td>
<td>Codes Reported Together 95% or More / Modifier -51 Exempt</td>
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<td><strong>2020 Medicare Utilization:</strong> 37,808</td>
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<td>Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed</td>
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<td>Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed</td>
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<td>Issue: Diagnostic Cardiac Catheterization</td>
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<th>93455</th>
<th>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</th>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 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 | 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: 2020 Medicare Utilization: 17,270 |
| RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00 | Referred to CPT October 2009 | Result: Decrease |

### 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 | Issue: Diagnostic Cardiac Catheterization | Screen: Codes Reported Together 95% or More Complete? Yes |
|---|---|---|---|
| RUC Recommendation: 7.66 | Referred to CPT October 2009 | Result: Decrease |

### 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 | Issue: Diagnostic Cardiac Catheterization | Screen: Codes Reported Together 95% or More Complete? Yes |
|---|---|---|---|
| RUC Recommendation: 6.51 | Referred to CPT October 2009 | Result: Decrease |
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>93460</td>
<td>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</td>
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<td>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</td>
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<td>93462</td>
<td>Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)</td>
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<td>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)</td>
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#### 93510
- **Most Recent RUC Meeting:** February 2009
- **Tab:** 31
- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT: October 2009

Referred to CPT Asst: Published in CPT Asst: Yes

#### 93511
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 26
- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT: October 2009

Referred to CPT Asst: Published in CPT Asst: Yes

#### 93514
- **Most Recent RUC Meeting:** April 2010
- **Tab:** 26
- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**

RUC Recommendation: Deleted from CPT

Referred to CPT: October 2009

Referred to CPT Asst: Published in CPT Asst: Yes
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**93524**
- **Most Recent RUC Meeting:** April 2010
- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **Medicare Utilization:**
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- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**
- **Referred to CPT:** October 2009
- **Result:** Deleted from CPT
- **Published in CPT Asst:**

**93526**
- **Most Recent RUC Meeting:** February 2008
- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **Medicare Utilization:**
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- **Referred to CPT:** October 2009
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- **Published in CPT Asst:**

**93527**
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- **Specialty Developing Recommendation:** ACC
- **First Identified:** February 2008
- **Medicare Utilization:**
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**CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000**
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### Status Report: CMS Requests and Relativity Assessment Issues

#### 93556
- **Deleted from CPT**
- **Global:** ACC
- **Issue:** Cardiac Catheterization
- **First Identified:** February 2008
- **RUC Recommendation:** Deleted from CPT
- **Tab:** 31
- **Screen:**
  - Codes Reported
  - Together 95% or More / CMS Request - Practice Expense Review
- **Complete?** Yes
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**
- **Result:** Deleted from CPT
- **Referred to CPT:** October 2009
- **Referred to CPT Asst:**
- **Published in CPT Asst:**

#### 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
- **First Identified:** October 2017
- **RUC Recommendation:**
- **Tab:** 27
- **Screen:** Negative IWPUT
- **Complete?** Yes
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**
- **Result:** Increase
- **Referred to CPT**
- **Referred to CPT Asst**
- **Published in CPT Asst**

#### 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
- **First Identified:** October 2017
- **RUC Recommendation:**
- **Tab:** 27
- **Screen:** Negative IWPUT
- **Complete?** Yes
- **2020 Medicare Utilization:**
  - **2022 Work RVU:**
  - **2022 NF PE RVU:**
  - **2022 Fac PE RVU:**
- **Result:** Increase
- **Referred to CPT**
- **Referred to CPT Asst**
- **Published in CPT Asst**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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)</td>
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### Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective 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)

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### 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)

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### 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)

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## 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)**

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#### Most Recent RUC Meeting:
- **April 2011**

#### Specialty Developing Recommendation:
- **ACC**

#### First Identified:
- **2020**

#### Medicare Utilization:
- **21,505**

#### RUC Recommendation:
- **0.97**

#### Referred to CPT:
- **October 2009**

#### Published in CPT Asst:
- **No**

#### Result:
- **Decrease**

### 93568
**Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (list separately in addition to code for primary procedure)**

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#### Most Recent RUC Meeting:
- **April 2011**

#### Specialty Developing Recommendation:
- **ACC**

#### First Identified:
- **2020**

#### Medicare Utilization:
- **1,132**

#### RUC Recommendation:
- **0.98**

#### Referred to CPT:
- **October 2009**

#### Published in CPT Asst:
- **No**

#### Result:
- **Decrease**

### 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)**

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<th>Issue</th>
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<td>ZZZ</td>
<td>Coronary Flow Reserve Measurement</td>
<td>High Volume Growth4</td>
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#### Most Recent RUC Meeting:
- **October 2017**

#### Specialty Developing Recommendation:
- **ACC, SCAI**

#### First Identified:
- **October 2016**

#### Medicare Utilization:
- **62,062**

#### RUC Recommendation:
- **1.50**

#### Referred to CPT:
- **No**

#### Published in CPT Asst:
- **No**

#### Result:
- **Decrease**
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>93572</td>
<td>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)</td>
<td>ZZZ</td>
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<td>93613</td>
<td>Intracardiac electrophysiologic 3-dimensional mapping (list separately in addition to code for primary procedure)</td>
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<td>Cardiac Ablation Services Bundling</td>
<td>CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2</td>
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<td>93620</td>
<td>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</td>
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**Intracardiac 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)**

**Intracardiac electrophysiologic 3-dimensional mapping (list separately in addition to code for primary procedure)**

**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**
**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)

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### 93623 Programmed stimulation and pacing after intravenous drug infusion (list separately in addition to code for primary procedure)

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### 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

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Referred to CPT  | February 2011  | Referred to CPT Asst  | Published in CPT Asst: |
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<td>Intracardiac catheter ablation of arrhythmogenic focus; for treatment of</td>
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<td>Bundling EPS with Transcatheter Ablation</td>
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<td>supraventricular tachycardia by ablation of fast or slow atrioventricular</td>
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<td>pathways, accessory atrioventricular connections or other atrial foci, singly</td>
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<td>93652</td>
<td>Intracardiac catheter ablation of arrhythmogenic focus; for treatment of</td>
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<td>Bundling EPS with Transcatheter Ablation</td>
<td>Codes Reported Together 75% or More-Part1</td>
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<td></td>
<td>ventricular tachycardia</td>
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<td>93653</td>
<td>Comprehensive electrophysiologic evaluation with insertion and repositioning</td>
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<td>of multiple electrode catheters, induction or attempted induction of an</td>
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<td>arrhythmia with right atrial pacing and recording and catheter ablation of</td>
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<td>arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional</td>
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<td>mapping, right ventricular pacing and recording, left atrial pacing and</td>
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<td>recording from coronary sinus or left atrium, and his bundle recording, when</td>
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<td>performed; with treatment of supraventricular tachycardia by ablation of fast</td>
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<td>or slow atrioventricular pathway, accessory atrioventricular connection, cavo-</td>
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<td>tricuspid isthmus or other single atrial focus or source of atrial re-entry</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>93654</td>
<td>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</td>
<td>000</td>
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<td>Codes Reported Together 75% or More-Part1</td>
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<td>93655</td>
<td>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)</td>
<td>ZZZ</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 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

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<th>Specialty Developing Recommendation: ACC, HRS</th>
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<th>Screen: Codes Reported Together 75% or More-Part1 / High Volume Growth6</th>
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<td>2022 Fac PE RVU: 8.51</td>
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#### Referred to CPT: October 2020

#### Referred to CPT Asst: Published in CPT Asst:

### 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)

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#### Referred to CPT: October 2011

#### 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)

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#### Referred to CPT: |

#### Referred to CPT Asst: Published in CPT Asst:

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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>93668</td>
<td>Peripheral arterial disease (PAD) rehabilitation, per session</td>
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<td>Peripheral Artery Disease (PAD) Rehabilitation (PE Only)</td>
<td>CMS Request - Final Rule for 2018</td>
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**Most Recent RUC Meeting:** January 2018  
**Specialty Developing Recommendation:** New PE Inputs  
**First Identified:** July 2017  
**2020 Medicare Utilization:** 1,257  
**Result:** PE Only  

| 93701 | Bioimpedance-derived physiologic cardiovascular analysis | XXX | | Low Value-High Volume | Yes |

**Most Recent RUC Meeting:** February 2011  
**Specialty Developing Recommendation:** Remove from screen  
**First Identified:** October 2010  
**2020 Medicare Utilization:** 6,330  
**Result:** Remove from Screen  

| 93731 | Deleted from CPT | | Cardiology Services | CMS Fastest Growing | Yes |

**Most Recent RUC Meeting:** October 2008  
**Specialty Developing Recommendation:** ACC  
**First Identified:** October 2008  
**Result:** Deleted from CPT  

| 93732 | Deleted from CPT | | Cardiology Services | CMS Fastest Growing | Yes |

**Most Recent RUC Meeting:** October 2008  
**Specialty Developing Recommendation:** ACC  
**First Identified:** October 2008  
**Result:** Deleted from CPT
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<td>Cardiology Services</td>
<td>CMS Fastest Growing</td>
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| Most Recent RUC Meeting: October 2008 | Tab: 26 | Specialty Developing Recommendation: ACC |

**Issue:** Deleted from CPT

**First Identified:** October 2008

**2020 Medicare Utilization:**

**2022 Work RVU:**

**2022 NF PE RVU:**

**2022 Fac PE RVU:**

**Result:** Deleted from CPT

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**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**

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<td>XXX</td>
<td>Ventricular Assist Device (VAD) Interrogation</td>
<td>High Volume Growth5</td>
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| Most Recent RUC Meeting: April 2019 | Tab: 24 | Specialty Developing Recommendation: AATS, ACC, STS |

**First Identified:** October 2018

**2020 Medicare Utilization:** 87,483

**2022 Work RVU:** 0.75

**2022 NF PE RVU:** 0.62

**2022 Fac PE RVU:** 0.31

**Result:** Decrease

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Tuesday, February 1, 2022
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<td>93792</td>
<td>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.</td>
<td>XXX</td>
<td>Home INR Monitoring</td>
<td>High Volume Growth3 / Work Neutrality 2018</td>
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<td>93793</td>
<td>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.</td>
<td>XXX</td>
<td>Home INR Monitoring</td>
<td>High Volume Growth3 / Work Neutrality 2018</td>
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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.

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.

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## Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 33  
**Specialty Developing Recommendation:** ACR, ACC, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 1,741,221  
**2022 Work RVU:** 0.80  
**2022 NF PE RVU:** 4.86  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.80  
**Referred to CPT:** October 2010  
**Referred to CPT Asst:** Yes  
**Result:** Increase  
**Published in CPT Asst:** Addressed in CPT Coding Changes

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 33  
**Specialty Developing Recommendation:** ACC, ACR, SVS  
**First Identified:** January 2012  
**2020 Medicare Utilization:** 26,394  
**2022 Work RVU:** 0.50  
**2022 NF PE RVU:** 3.17  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 0.50  
**Referred to CPT:**  
**Referred to CPT Asst:** No  
**Result:** Increase  
**Published in CPT Asst:**

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 33  
**Specialty Developing Recommendation:** AAN, ACC, ACR, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 91,514  
**2022 Work RVU:** 0.91  
**2022 NF PE RVU:** 7.09  
**2022 Fac PE RVU:** NA  
**RUC Recommendation:** 1.00  
**Referred to CPT:** October 2010  
**Referred to CPT Asst:** No  
**Result:** Increase  
**Published in CPT Asst:**

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**Tuesday, February 1, 2022**

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## Status Report: CMS Requests and Relativity Assessment Issues

### 93888  Transcranial doppler study of the intracranial arteries; limited study

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**Most Recent RUC Meeting:** April 2014  
**Tab:** 33  
**Specialty Developing Recommendation:** AAN, ACC, ACR, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 8,867  
**2022 Work RVU:** 0.70  
**2022 NF PE RVU:** 4.26  
**2022 Fac PE RVU:** NA

**RUC Recommendation:** Yes  
**Referred to CPT:** October 2010  
**Result:** Increase

**Screen:**  
**Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014**

**Published in CPT Asst:**

### 93890  Transcranial doppler study of the intracranial arteries; vasoreactivity study

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**Most Recent RUC Meeting:** January 2020  
**Tab:** 37  
**Specialty Developing Recommendation:**  
**First Identified:** October 2019  
**2020 Medicare Utilization:** 49,307  
**2022 Work RVU:** 1.00  
**2022 NF PE RVU:** 7.17  
**2022 Fac PE RVU:** NA

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

**Result:** Remove from Screen

**Screen:**

**High Volume Growth6**

**Published in CPT Asst:**

### 93892  Transcranial doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection

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**Most Recent RUC Meeting:** January 2020  
**Tab:** 37  
**Specialty Developing Recommendation:**  
**First Identified:** October 2019  
**2020 Medicare Utilization:** 51,633  
**2022 Work RVU:** 1.15  
**2022 NF PE RVU:** 8.17  
**2022 Fac PE RVU:** NA

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

**Result:** Remove from Screen

**Screen:**

**High Volume Growth6**

**Published in CPT Asst:**
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<td>93922</td>
<td>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)</td>
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<td>Extremity Non-Invasive Arterial Physiologic Studies</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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)</td>
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<td>Extremity Non-Invasive Arterial Physiologic Studies</td>
<td>CMS Fastest Growing</td>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 27  
**Specialty Developing Recommendation:** SVS, ACR, ACC  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 347,656

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**RUC Recommendation:** 0.45  
**Referred to CPT:** February 2010  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Maintain

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<td>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</td>
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<td>Extremity Non-Invasive Arterial Physiologic Studies</td>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 27  
**Specialty Developing Recommendation:** SVS, ACR, ACC  
**First Identified:** February 2009  
**2020 Medicare Utilization:** 44,449

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**RUC Recommendation:** 0.50  
**Referred to CPT:** February 2010  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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### Duplex Scans

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**Most Recent RUC Meeting:** April 2014  
**Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 42,036  
**RUC Recommendation:** 0.50  
**Referred to CPT:** October 2010  
**Result:** Increase

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<td>Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborehography, impedance plethysmography)</td>
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**Most Recent RUC Meeting:** January 2016  
**Specialty Developing Recommendation:** ACC, ACR, SCAI, SVS  
**First Identified:** July 2015  
**2020 Medicare Utilization:** 2022 NF PE RVU: NA  
**RUC Recommendation:** Deleted from CPT  
**Referred to CPT Asst:** May 2016  
**Result:** Deleted from CPT

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**Most Recent RUC Meeting:** April 2014  
**Specialty Developing Recommendation:** ACC, ACR, SVS  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 1,390,491  
**RUC Recommendation:** 0.70  
**Referred to CPT Asst:** Published in CPT Asst:  
**Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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## 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

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### 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

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### 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

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**Status Report: CMS Requests and Relativity Assessment Issues**

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| 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 | XXX    | Pulmonary Tests | High Volume Growth1 | Yes       | 0.52   |
|        | First RUC Meeting: February 2008                                              |        |             |                         |           |        |
|        | Specialty Developing Recommendation: ACCP/ATS                                 |        |             |                         |           |        |
|        | Most Recent RUC Meeting: February 2008                                        |        |             |                         |           |        |
|        | Cause: ACCP/ATS                                                               |        |             |                         |           |        |
|        | RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS |        |             |                         |           |        |
|        | Referral to CPT                                                               |        |             |                         |           |        |
|        | Referral to CPT Asst                                                          |        |             |                         |           |        |
|        | Published in CPT Asst                                                         |        |             |                         |           |        |
|        | 2020 Medicare utilization: 142                                                |        |             |                         |           |        |
|        | 2022 Work RVU: 0.52                                                           |        |             |                         |           |        |
|        | 2022 NF PE RVU: 1.07                                                          |        |             |                         |           |        |
|        | 2022 Fac PE RVU: NA                                                           |        |             |                         |           |        |

| 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) | XXX    | Pulmonary Tests | High Volume Growth1 | Yes       | 0.00   |
|        | First RUC Meeting: February 2008                                              |        |             |                         |           |        |
|        | Specialty Developing Recommendation: ACCP/ATS                                 |        |             |                         |           |        |
|        | Most Recent RUC Meeting: February 2008                                        |        |             |                         |           |        |
|        | Cause: ACCP/ATS                                                               |        |             |                         |           |        |
|        | RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS |        |             |                         |           |        |
|        | Referral to CPT                                                               |        |             |                         |           |        |
|        | Referral to CPT Asst                                                          |        |             |                         |           |        |
|        | Published in CPT Asst                                                         |        |             |                         |           |        |
|        | 2020 Medicare utilization: 24                                                 |        |             |                         |           |        |
|        | 2022 Work RVU: 0.00                                                           |        |             |                         |           |        |
|        | 2022 NF PE RVU: 0.89                                                          |        |             |                         |           |        |
|        | 2022 Fac PE RVU: NA                                                           |        |             |                         |           |        |
### 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**

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**94060**
**Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration**

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**94200**
**Maximum breathing capacity, maximal voluntary ventilation**

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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

**94240** Deleted from CPT

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**94250** Expired gas collection, quantitative, single procedure (separate procedure)

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| 2022 Work RVU: |
| 2022 NF PE RVU: |

**94260** Deleted from CPT

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## Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>94720</td>
<td>Carbon monoxide diffusing capacity (eg, single breath, steady state)</td>
<td>XXX</td>
<td>Pulmonary Tests</td>
<td>Codes Reported Together 75% or More-Part1</td>
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<td>Most Recent RUC Meeting: April 2010</td>
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<td>NF PE RVU:</td>
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# Status Report: CMS Requests and Relativity Assessment Issues

## 94725  Membrane diffusion capacity

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<th>Screen: Codes Reported Together 75% or More-Part1</th>
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**Most Recent RUC Meeting:** April 2010  
**Tab:** 45  
**Specialty Developing Recommendation:** ACCP, ATS  
**First Identified:** February 2010  
**2020 Medicare Utilization:**

- **2022 Work RVU:**
- **2022 NF PE RVU:**
- **2022 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** October 2010  
**Published in CPT Asst:**

## 94726  Plethysmography for determination of lung volumes and, when performed, airway resistance

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**Most Recent RUC Meeting:** April 2011  
**Tab:** 19  
**Specialty Developing Recommendation:** ACCP, ATS  
**First Identified:** February 2010  
**2020 Medicare Utilization:**

- **2022 Work RVU:** 0.26  
- **2022 NF PE RVU:** 1.32  
- **2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.31  
**Referred to CPT:** February 2011  
**Result:** Decrease  
**Published in CPT Asst:**

## 94727  Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes

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**Most Recent RUC Meeting:** April 2011  
**Tab:** 19  
**Specialty Developing Recommendation:** ACCP, ATS  
**First Identified:** February 2010  
**2020 Medicare Utilization:**

- **2022 Work RVU:** 0.26  
- **2022 NF PE RVU:** 1.01  
- **2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.31  
**Referred to CPT:** February 2011  
**Result:** Decrease  
**Published in CPT Asst:**

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<td>94729</td>
<td>Diffusing capacity (eg, carbon monoxide, membrane) (list separately in addition to code for primary procedure)</td>
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<td>94750</td>
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<td>RAW</td>
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<td>94762</td>
<td>Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight</td>
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<td>monitoring (separate procedure)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
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<th>Issue</th>
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<td>95004</td>
<td>Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests</td>
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<td>95010</td>
<td>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</td>
<td>JCAAI, ACAAI, AAAAAI</td>
<td>Percutaneous Allergy Tests</td>
<td>Low Value-Billed in Multiple Units</td>
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#### 94770 Carbon dioxide, expired gas determination by infrared analyzer

**Global:** ATS, CHEST  
**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: | Specialty Developing Recommendation:  
| First Identified: | February 2008  
| 2020 Medicare Utilization: | 2,651  
| Referred to CPT | September 2019  
| Referred to CPT Asst | Published in CPT Asst: Mar 2014  
| Result | Deleted from CPT

| Most Recent RUC Meeting: | October 2010  
| Tab:  | 27  
| Specialty Developing Recommendation: | Specialty Developing Recommendation:  
| First Identified: | October 2010  
| 2020 Medicare Utilization: | 7,781,153  
| Referred to CPT | February 2012  
| Referred to CPT Asst | Published in CPT Asst:  
| Result | Maintained

| Most Recent RUC Meeting: | April 2011  
| Tab:  | 31  
| Specialty Developing Recommendation: | Specialty Developing Recommendation:  
| First Identified: | October 2010  
| 2020 Medicare Utilization: |  
| Referred to CPT |  
| Referred to CPT Asst |  
| Result | Deleted from CPT

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<th>CPT Code</th>
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<td>Exhaled Nitric Oxide Measurement (PE Only)</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Screen: Low Value-Billed in Multiple Units</th>
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<tr>
<td>95018</td>
<td>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</td>
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<td>Most Recent RUC Meeting: April 2012</td>
<td>Tab: 29</td>
<td>Specialty Developing Recommendation: JCAAI</td>
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<td>95024</td>
<td>Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests</td>
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<td>95027</td>
<td>Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>95115</td>
<td>Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection</td>
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<td>Immunochemistry</td>
<td>CMS High Expenditure Procedural Codes</td>
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**RUC Recommendation:** New PE Inputs

**First Identified:** January 2012

**Medicare Utilization:** 859,372

**Referred to CPT**

**Published in CPT Asst:**

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<td>95117</td>
<td>Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections</td>
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<td>Immunochemistry</td>
<td>CMS High Expenditure Procedural Codes</td>
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**RUC Recommendation:** New PE Inputs

**First Identified:** September 2011

**Medicare Utilization:** 2,434,986

**Referred to CPT**

**Published in CPT Asst:**

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<tr>
<td>95144</td>
<td>Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)</td>
<td>XXX</td>
<td>Antigen Therapy Services</td>
<td>Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes</td>
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**RUC Recommendation:** 0.06

**First Identified:** October 2010

**Medicare Utilization:** 155,016

**Referred to CPT**

**Published in CPT Asst:**

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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
<th>Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms</th>
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<td>95148</td>
<td>Most Recent RUC Meeting: October 2010 Tab: 73 Specialty Developing Recommendation:</td>
<td>First Identified: October 2010 2020 Medicare Utilization: 18,559</td>
<td>2022 Work RVU: 0.06</td>
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<th>Code</th>
<th>Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: MPC List / CMS High Expenditure Procedural Codes2</th>
<th>Complete?</th>
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<td>95165</td>
<td>Most Recent RUC Meeting: January 2016 Tab: 49 Specialty Developing Recommendation: AAOHNS, AAOA, ACAAI</td>
<td>First Identified: October 2010 2020 Medicare Utilization: 6,673,468</td>
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<thead>
<tr>
<th>Code</th>
<th>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</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: High Volume Growth2</th>
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<th>Yes</th>
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<tr>
<td>95249</td>
<td>Most Recent RUC Meeting: April 2017 Tab: 08 Specialty Developing Recommendation: AACE, ES, ACP</td>
<td>First Identified:</td>
<td>2020 Medicare Utilization: 10,344</td>
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</table>
## 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

|-------------|--------------------------------------|--------------------------------------------------|-----------|-----|

**Most Recent RUC Meeting:** January 2020  
**Tab:** 37  
**Specialty Developing Recommendation:** AACE, ES  
**First Identified:** October 2013  
**2020 Medicare Utilization:** 48,697  

**RUC Recommendation:** Re-review at RAW. New PE inputs.  
**Referred to CPT:** October 2015 & February 2017  
**Published in CPT Asst:** |

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### 95251
Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

|-------------|--------------------------------------|--------------------------------------------------|-----------|-----|

**Most Recent RUC Meeting:** January 2020  
**Tab:** 37  
**Specialty Developing Recommendation:** AACE, ES  
**First Identified:** April 2013  
**2020 Medicare Utilization:** 296,345  

**RUC Recommendation:** Re-review at RAW. 0.70.  
**Referred to CPT:** February 2017  
**Published in CPT Asst:** |

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### 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

<table>
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<tr>
<th>Global: XXX</th>
<th>Issue: Long-Term EEG Monitoring</th>
<th>Screen: High Volume Growth4</th>
<th>Complete?</th>
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**Most Recent RUC Meeting:** October 2018  
**Tab:** 13  
**Specialty Developing Recommendation:** AAN, ACNS  
**First Identified:** May 2018  
**2020 Medicare Utilization:** 13,701  

**RUC Recommendation:** PE Only  
**Referred to CPT:**  
**Published in CPT Asst:** |

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Tuesday, February 1, 2022  
Page 722 of 836
## Status Report: CMS Requests and Relativity Assessment Issues

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<td>95705</td>
<td>Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; unmonitored</td>
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<td>95706</td>
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<td>Long-Term EEG Monitoring</td>
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<td>95707</td>
<td>Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; with continuous, real-time monitoring and maintenance</td>
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<tr>
<td>95708</td>
<td>Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; unmonitored</td>
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**Most Recent RUC Meeting:** October 2018

**Tab:** 13

**Specialty Developing Recommendation:** AAN, ACNS

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**2022 Work RVU:** 0.00

**2022 NF PE RVU:** 0.00

**2022 Fac PE RVU:** 0.00

**RUC Recommendation:** PE Only

**Result:** PE Only

**Published in CPT Asst:**

**Referred to CPT**

**Referred to CPT Asst**

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Tuesday, February 1, 2022

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## Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** October 2018  
**Tab:** 13  
**Specialty Developing Recommendation:** AAN, ACNS  
**First Identified:** May 2018  
**2020 Medicare Utilization:**  
| | | | | |
| **2022 Work RVU:** 0.00 | **2022 NF PE RVU:** 0.00 | **2022 Fac PE RVU:** 0.00 |

**RUC Recommendation:** PE Only  
**Referred to CPT:**  
**Referred to CPT Asst:**  
**Published in CPT Asst:**  
**Result:** PE Only
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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| RUC Recommendation: 3.86 | Referred to CPT | Published in CPT Asst: |

| Result: Decrease | |

| 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) | XXX    | Long-Term EEG Monitoring | High Volume Growth4                  | Yes       |


| RUC Recommendation: 4.70 | Referred to CPT | Published in CPT Asst: |

| Result: Decrease | |

| 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 | XXX    | Long-Term EEG Monitoring | High Volume Growth4                  | Yes       |


| RUC Recommendation: 4.75 | Referred to CPT | Published in CPT Asst: |

<p>| Result: Decrease | |</p>
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<td>Long-Term EEG Monitoring</td>
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**Most Recent RUC Meeting:** October 2018  
**Tab:** 13  
**Specialty Developing Recommendation:** AAN, ACNS  
**First Identified:** May 2018  
**2020 Medicare Utilization:** 4,668

**RUC Recommendation:** 6.00  
**Result:** Decrease  
**Referred to CPT Asst:** Published in CPT Asst:

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**Most Recent RUC Meeting:** October 2018  
**Tab:** 13  
**Specialty Developing Recommendation:** AAN, ACNS  
**First Identified:** May 2018  
**2020 Medicare Utilization:** 181

**RUC Recommendation:** 5.40  
**Result:** Decrease  
**Referred to CPT Asst:** Published in CPT Asst:

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**Most Recent RUC Meeting:** October 2018  
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**Specialty Developing Recommendation:** AAN, ACNS  
**First Identified:** May 2018  
**2020 Medicare Utilization:** 583

**RUC Recommendation:** 7.58  
**Result:** Decrease  
**Referred to CPT Asst:** Published in CPT Asst:
# Status Report: CMS Requests and Relativity Assessment Issues

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<td>95801</td>
<td>Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)</td>
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<td>Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)</td>
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Tuesday, February 1, 2022

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### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** April 2010  
**Tab:** 28  
**Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM  
**First Identified:** October 2009  
**RUC Recommendation:** 1.20  
**2020 Medicare Utilization:** 1,976  
**2022 Work RVU:** 1.20  
**2022 NF PE RVU:** 11.00  
**2022 Fac PE RVU:** NA  
**Result:** Decrease  

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**First Identified:** October 2009  
**RUC Recommendation:** 1.28  
**2020 Medicare Utilization:** 78,847  
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**2022 NF PE RVU:** 1.71  
**2022 Fac PE RVU:** NA  
**Result:** Decrease  

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**First Identified:** October 2009  
**RUC Recommendation:** 1.25  
**2020 Medicare Utilization:** 1,584  
**2022 Work RVU:** 1.28  
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**2022 Fac PE RVU:** NA  
**Result:** Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

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### 95808 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

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### 95808 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

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### 95812 Electroencephalogram (eeg) extended monitoring; 41-60 minutes

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## Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### 95861 Needle electromyography; 2 extremities with or without related paraspinal areas

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**Most Recent RUC Meeting:** April 2012  
**Tab:** 32  
**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 44,130  
**2022 Work RVU:** 1.54  
**2022 NF PE RVU:** 3.27  
**2022 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

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**2022 Work RVU:** 1.87  
**2022 NF PE RVU:** 4.44  
**2022 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:**

### 95864 Needle electromyography; 4 extremities with or without related paraspinal areas

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**2022 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:**

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<td>95868</td>
<td>Needle electromyography; cranial nerve supplied muscles, bilateral</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>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</td>
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<td>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)</td>
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<td>95886</td>
<td>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)</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

### 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)

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#### Most Recent RUC Meeting: April 2011

- **Tab:** 20
- **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA
- **First Identified:** February 2010
- **2020 Medicare Utilization:** 13,124

- **RUC Recommendation:** 0.73
- **Referred to CPT:** February 2011 and October 2011
- **Result:** Decrease

### 95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

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#### Most Recent RUC Meeting: April 2012

- **Tab:** 32
- **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA
- **First Identified:** October 2010
- **2020 Medicare Utilization:** 2020 NF PE RVU: 1.82, 2022 Fac PE RVU: NA

- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** October 2011 & February 2012
- **Result:** Deleted from CPT

### 95903 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

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#### Most Recent RUC Meeting: April 2012

- **Tab:** 32
- **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA
- **First Identified:** September 2011
- **2020 Medicare Utilization:** 2020 NF PE RVU: 1.82, 2022 Fac PE RVU: NA

- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** October 2011 and February 2012 & February 2012
- **Result:** Deleted from CPT

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*Tuesday, February 1, 2022*

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### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** April 2012  
**Tab:** 32  
**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA  
**First Identified:** February 2010  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Recommended RUC Action:** Referred to CPT  
**Recommended RUC Asst:** Published in CPT Asst:  
**Result:** Deleted from CPT

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**Recommended RUC Asst:** Published in CPT Asst:  
**Result:** Decrease

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**Most Recent RUC Meeting:** April 2012  
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**2022 NF PE RVU:** 2.08  
**2022 Fac PE RVU:** NA  
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**Recommended RUC Asst:** Published in CPT Asst:  
**Result:** Decrease

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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>(parasympathetic function), including 2 or more of the following: heart rate</td>
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<td>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</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<th>Code</th>
<th>Description</th>
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<td>95925</td>
<td>Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs</td>
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<td>Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013</td>
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#### Most Recent RUC Meeting: January 2013
- **Tab:** 34
- **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR
- **First Identified:** February 2010
- **2020 Medicare Utilization:** 4,511
- **2022 Work RVU:** 0.54
- **2022 NF PE RVU:** 4.87
- **2022 Fac PE RVU:** NA
- **RUC Recommendation:** 0.54 and New PE Inputs
- **Referred to CPT Asst:** Published in CPT Asst: October 2010
- **Result:** Maintain

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<th>Code</th>
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<tbody>
<tr>
<td>95926</td>
<td>Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs</td>
<td>XXX</td>
<td>Evoked Potentials and Reflex Studies</td>
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#### Most Recent RUC Meeting: January 2013
- **Tab:** 34
- **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR
- **First Identified:** February 2010
- **2020 Medicare Utilization:** 3,888
- **2022 Work RVU:** 0.54
- **2022 NF PE RVU:** 4.15
- **2022 Fac PE RVU:** NA
- **RUC Recommendation:** 0.54 and New PE Inputs
- **Referred to CPT Asst:** Published in CPT Asst: October 2010
- **Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Central motor evoked potential study (transcranial motor stimulation); upper limbs</td>
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<td>95929</td>
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<td>95930</td>
<td>Visual evoked potential (vep) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report</td>
<td>XXX</td>
<td>Visual Evoked Potential Testing</td>
<td>High Volume Growth3</td>
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#### Most Recent RUC Meeting
- **Central Motor Evoked Potential Study (upper limbs)**
  - **Tab:** 36
  - **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS
  - **First Identified:** February 2010
  - **2020 Medicare Utilization:** 306
  - **RUC Recommendation:** 1.50
  - **Sent to CPT:** October 2010
  - **Result:** Maintain

#### Most Recent RUC Meeting
- **Central Motor Evoked Potential Study (lower limbs)**
  - **Tab:** 36
  - **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS
  - **First Identified:** February 2010
  - **2020 Medicare Utilization:** 1,340
  - **RUC Recommendation:** 1.50
  - **Sent to CPT:** October 2010
  - **Result:** Maintain

#### Most Recent RUC Meeting
- **Visual Evoked Potential Testing**
  - **Tab:** 11
  - **Specialty Developing Recommendation:** AAO, AOA (optometry), ACNS
  - **First Identified:** October 2015
  - **2020 Medicare Utilization:** 38,305
  - **RUC Recommendation:** 0.35
  - **Sent to CPT:** May 2016
  - **Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>95936</td>
<td><strong>EMG in Conjunction with Nerve Testing</strong>&lt;br&gt;H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle</td>
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<td>95939</td>
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**RUC Recommendation:** 2.25 and new PE inputs  
**First Identified:** January 2013  
**2020 Medicare Utilization:** 42,469  
**Result:** Decrease  

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<td>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)</td>
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<td>Intraoperative Neurophysiology Monitoring</td>
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**RUC Recommendation:** 0.60  
**First Identified:** January 2012  
**2020 Medicare Utilization:** 25,219  
**Result:** Decrease  

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<tr>
<td>95941</td>
<td>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)</td>
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<td>Intraoperative Neurophysiology Monitoring</td>
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**RUC Recommendation:** 2.00  
**First Identified:** January 2012  
**2020 Medicare Utilization:** 25,219  
**Result:** Decrease
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>95943</td>
<td>Simultaneous, independent, quantitative measures of both parasympathetic</td>
<td>XXX</td>
<td>Autonomic Function Testing</td>
<td>Codes Reported: Together 75% or More-Part1 / Contractor Priced High Volume</td>
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<td>function and sympathetic function, based on time-frequency analysis of heart</td>
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<td>rate variability concurrent with time-frequency analysis of continuous</td>
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<td>respiratory activity, with mean heart rate and blood pressure measures, during</td>
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| 95950  | Monitoring for identification and lateralization of cerebral seizure focus, | Global | Issue: Long-Term EEG Monitoring | Screen: CMS Fastest Growing | Complete? |
|        | electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours |        |                             |                                                                 | Yes       |
| Most Recent | RUC Meeting: October 2018                                                                                               |        |                             |                                                                 |           |
| Tab: 13 | Specialty Developing Recommendation: AAN, ACNS                                                                          |        |                             |                                                                 |           |
| First | Identified: February 2009                                                                                                 |        |                             |                                                                 |           |
| 2020 | Medicare Utilization:                                                                                                     |        |                             |                                                                 |           |
| 2022 Work RVU: |                                                                               |        |                             |                                                                 |           |
| 2022 NF PE RVU: |                                                                              |        |                             |                                                                 |           |
| 2022 Fac PE RVU: |                                                                             |        |                             |                                                                 |           |
| RUC Recommendation: | Deleted from CPT                                                             |        |                             |                                                                 |           |
| Referred to CPT |                                                                              |        |                             |                                                                 |           |
| Referred to CPT Asst |                                                                              |        |                             |                                                                 |           |
| Result: | Deleted from CPT                                                             |        |                             |                                                                 |           |

<p>| 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? |
| Most Recent | RUC Meeting: October 2018                                                                                               |        |                             |                                                                 | Yes       |
| Tab: 13 | Specialty Developing Recommendation:                                                                                   |        |                             |                                                                 |           |
| First | Identified: October 2016                                                                                                 |        |                             |                                                                 |           |
| 2020 | Medicare Utilization:                                                                                                    |        |                             |                                                                 |           |
| 2022 Work RVU: |                                                                               |        |                             |                                                                 |           |
| 2022 NF PE RVU: |                                                                              |        |                             |                                                                 |           |
| 2022 Fac PE RVU: |                                                                             |        |                             |                                                                 |           |
| RUC Recommendation: | Deleted from CPT                                                             |        |                             |                                                                 |           |
| Referred to CPT |                                                                              |        |                             |                                                                 |           |
| Referred to CPT Asst |                                                                              |        |                             |                                                                 |           |
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<td>Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended</td>
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<td>95954</td>
<td>Pharmacological or physical activation requiring physician or other qualified health care professional attendance during eeg recording of activation phase (eg, thiopental activation test)</td>
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<td>EEG Monitoring</td>
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<td>95956</td>
<td>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</td>
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<td>XXX</td>
<td>Neurostimulator Services</td>
<td>Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018</td>
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<td>XXX</td>
<td>Neurostimulator Services</td>
<td>Harvard Valued - Utilization over 100,000 / High Volume Growth2</td>
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<td>October 2017</td>
<td>07</td>
<td>AAPG, ACOG, AAPM, SIS, ACNS</td>
<td>October 2009</td>
<td>15,859</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<td>(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</td>
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<td>Specialty Developing Recommendation: AUA, ACOG, AAPM, SIS, ACNS</td>
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<td>95973</td>
<td>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)</td>
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<td>Implanted Neurostimulator Electronic Analysis</td>
<td>Harvard Valued - Utilization over 100,000 / Final Rule for 2015</td>
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Tuesday, February 1, 2022
**Status Report: CMS Requests and Relativity Assessment Issues**

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<td>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</td>
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<td>Neurostimulator Services</td>
<td>CMS Request - Final Rule for 2016</td>
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- **Most Recent RUC Meeting:** October 2017
- **Tab:** 07
- **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS
- **First Identified:** July 2015
- **2020 Medicare Utilization:**
  - 2022 Work RVU:
  - 2022 NF PE RVU:
  - 2022 Fac PE RVU:
- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** June 2017
- **Referred to CPT Asst:**
- **Published in CPT Asst:** Jul 2016

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<td>95975</td>
<td>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)</td>
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<td>Neurostimulator Services</td>
<td>CMS Request - Final Rule for 2016</td>
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- **Most Recent RUC Meeting:** October 2017
- **Tab:** 07
- **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS
- **First Identified:** July 2015
- **2020 Medicare Utilization:**
  - 2022 Work RVU:
  - 2022 NF PE RVU:
  - 2022 Fac PE RVU:
- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT:** June 2017
- **Referred to CPT Asst:**
- **Published in CPT Asst:** Jul 2016
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Neurostimulator Services</td>
<td>High Volume Growth2</td>
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**Most Recent RUC Meeting:** October 2017  
**Tab:** 07  
**Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS  
**First Identified:** June 2017  
**2020 Medicare Utilization:** 6,654  
**2022 Work RVU:** 0.73  
**2022 NF PE RVU:** 0.38  
**2022 Fac PE RVU:** 0.36  
**Result:** Maintain  
**Referred to CPT:** June 2017  
**Referred to CPT Asst:** Published in CPT Assistant: February 2019

- **Screen:** CMS Request - Final Rule for 2016

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<td>XXX</td>
<td>Neurostimulator Services</td>
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**Most Recent RUC Meeting:** October 2017  
**Tab:** 07  
**Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS  
**First Identified:** June 2017  
**2020 Medicare Utilization:** 5,033  
**2022 Work RVU:** 0.97  
**2022 NF PE RVU:** 0.50  
**2022 Fac PE RVU:** 0.47  
**Result:** Maintain  
**Referred to CPT:** June 2017  
**Referred to CPT Asst:** Published in CPT Assistant: February 2019

- **Screen:** CMS Request - Final Rule for 2016

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<td>95978</td>
<td>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</td>
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<td>Neurostimulator Services</td>
<td>CMS Request - Final Rule for 2016</td>
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**Most Recent RUC Meeting:** October 2017  
**Tab:** 07  
**Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS  
**First Identified:** July 2015  
**2020 Medicare Utilization:** |  
**2022 Work RVU:** |  
**2022 NF PE RVU:** |  
**2022 Fac PE RVU:** |  
**Result:** Deleted from CPT  
**Referred to CPT:** June 2017  
**Referred to CPT Asst:** Published in CPT Assistant: July 2016

- **Screen:** CMS Request - Final Rule for 2016
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<th>Medicare Utilization</th>
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<tr>
<td>95979</td>
<td>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)</td>
<td>Global:</td>
<td>Neurostimulator Services</td>
<td>Screen: CMS Request - Final Rule for 2016</td>
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<td>07</td>
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<td>95980</td>
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<td>Screen: CMS Request - Final Rule for 2016</td>
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<td>95981</td>
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<td>Neurostimulator Services</td>
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Electronic analysis of implanted neurostimulator pulse generator (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

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.
### Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** October 2017  
**Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS  
**First Identified:** June 2017  
**2020 Medicare Utilization:** 45,873  
**2022 Work RVU:** 0.80  
**2022 NF PE RVU:** 0.42  
**2022 Fac PE RVU:** 0.40

- **RUC Recommendation:** 1.00 and Refer to CPT Assistant  
- **Referred to CPT:** June 2017  
- **Referred to CPT Asst Published in CPT Asst:** February 2019

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<td>95990</td>
<td>Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;</td>
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<td>Electronic Analysis Implanted Pump</td>
<td>Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1</td>
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**Most Recent RUC Meeting:** February 2011  
**Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS  
**First Identified:** April 2010  
**2020 Medicare Utilization:** 947  
**2022 Work RVU:** 0.00  
**2022 NF PE RVU:** 2.65  
**2022 Fac PE RVU:** NA

- **RUC Recommendation:** 0.00  
- **Referred to CPT:** October 2010  
- **Referred to CPT Asst Published in CPT Asst:**

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<tr>
<td>95991</td>
<td>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</td>
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<td>Electronic Analysis Implanted Pump</td>
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**Most Recent RUC Meeting:** February 2011  
**Specialty Developing Recommendation:** ASA, AAPM  
**First Identified:** February 2008  
**2020 Medicare Utilization:** 7,441  
**2022 Work RVU:** 0.77  
**2022 NF PE RVU:** 2.40  
**2022 Fac PE RVU:** 0.32

- **RUC Recommendation:** 0.77  
- **Referred to CPT:** October 2010  
- **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

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- **RUC Recommendation:** Remove from Modifier -51 Exempt list.
- **Referred to CPT Asst:** Published in CPT Asst: Yes

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**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

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<td>CMS High Expenditure Procedural Codes2</td>
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- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT Asst:** Published in CPT Asst: Yes

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**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

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<td>Psychological and Neuro-psychological Testing</td>
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- **RUC Recommendation:** Deleted from CPT
- **Referred to CPT Asst:** Published in CPT Asst: Yes
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<td>96103</td>
<td>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</td>
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<td>High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2</td>
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<td>96105</td>
<td>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</td>
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<td>96110</td>
<td>Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>96120</td>
<td>Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
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<td>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)</td>
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<td>96125</td>
<td>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</td>
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<td>96127</td>
<td>Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [adhd] scale), with scoring and documentation, per standardized instrument</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<tr>
<th>Procedure Description</th>
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<th>Tab</th>
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<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
<th>Published in CPT Asst</th>
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| 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 | XXX    | Health and Behavior Assessment and Intervention | Negative IWPUT | Yes       |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |
| Most Recent RUC Meeting: January 2019 | Tab: 41 | Specialty Developing Recommendation: | First Identified: September 2018 | 2020 Medicare Utilization: |           |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |
|          | Most Recent RUC Meeting: January 2019                                                                                                         |        |                               |                         |           |
|          | Tab: 41 | Specialty Developing Recommendation: | First Identified: September 2018 | 2020 Medicare Utilization: |           |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |

<p>| 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 | XXX    | Health and Behavior Assessment and Intervention | Negative IWPUT | Yes       |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |
| Most Recent RUC Meeting: January 2019 | Tab: 41 | Specialty Developing Recommendation: | First Identified: September 2018 | 2020 Medicare Utilization: |           |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |
|          | Most Recent RUC Meeting: January 2019                                                                                                         |        |                               |                         |           |
|          | Tab: 41 | Specialty Developing Recommendation: | First Identified: September 2018 | 2020 Medicare Utilization: |           |
|          | RUC Recommendation: Deleted from CPT                                                                                                          |        |                               |                         |           |</p>
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## Status Report: CMS Requests and Relativity Assessment Issues

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**Most Recent RUC Meeting:** January 2019  
**Tab:** 41  
**Specialty Developing Recommendation:**  
**First Identified:** September 2018  
**Medicare Utilization:**  

**RUC Recommendation:** Deleted from CPT  
**Referred to CPT:** September 2018  
**Referred to CPT Asst:** No  
**Published in CPT Asst:** No  

| 96156    | Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making) | XXX    | Health and Behavior Assessment and Intervention | Negative IWPUT | Yes |

**Most Recent RUC Meeting:** January 2019  
**Tab:** 41  
**Specialty Developing Recommendation:**  
**First Identified:** September 2018  
**Medicare Utilization:**  

**RUC Recommendation:** 2.10  
**Referred to CPT:** September 2018  
**Referred to CPT Asst:** No  
**Published in CPT Asst:** No  

| 96158    | Health behavior intervention, individual, face-to-face; initial 30 minutes | XXX    | Health and Behavior Assessment and Intervention | Negative IWPUT | Yes |

**Most Recent RUC Meeting:** January 2019  
**Tab:** 41  
**Specialty Developing Recommendation:**  
**First Identified:** September 2018  
**Medicare Utilization:**  

**RUC Recommendation:** 1.45  
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## 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)**

<table>
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**Most Recent RUC Meeting:** January 2019  
**Tab:** 41  
**Specialty Developing Recommendation:**

- **First Identified:** September 2018  
- **2020 Medicare Utilization:**
  - Work RVU: 0.54  
- **2022 NF PE RVU:** 0.26  
- **2022 Fac PE RVU:** 0.21

**RUC Recommendation:** 0.54

- **Result:** Increase

**Referred to CPT:** September 2018  
**Referred to CPT Asst:**

- **Published in CPT Asst:**

### 96360
**Intravenous infusion, hydration; initial, 31 minutes to 1 hour**

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**Most Recent RUC Meeting:** January 2017  
**Tab:** 25  
**Specialty Developing Recommendation:** ASCO, ASH

- **First Identified:** July 2015  
- **2020 Medicare Utilization:**
  - Work RVU: 0.17  
- **2022 NF PE RVU:** 0.82  
- **2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.17

- **Result:** Maintain

**Referred to CPT:** N/A  
**Referred to CPT Asst:**

- **Published in CPT Asst:**

### 96361
**Intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure)**

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**Most Recent RUC Meeting:** January 2017  
**Tab:** 25  
**Specialty Developing Recommendation:** ASCO, ASH

- **First Identified:** July 2015  
- **2020 Medicare Utilization:**
  - Work RVU: 0.09  
- **2022 NF PE RVU:** 0.28  
- **2022 Fac PE RVU:** NA

**RUC Recommendation:** 0.09

- **Result:** Maintain

**Referred to CPT:** N/A  
**Referred to CPT Asst:**

- **Published in CPT Asst:**

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### Status Report: CMS Requests and Relativity Assessment Issues

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## Status Report: CMS Requests and Relativity Assessment Issues

### Intravenous Infusion Therapy

**Global:** ZZZ  
**Issue:** Intravenous Infusion Therapy  
**Screen:** CMS High Expenditure Procedural Codes1  
**Complete?** Yes

<table>
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<tr>
<th>Most Recent RUC Meeting:</th>
<th>January 2013</th>
<th>Tab: 28</th>
<th>Specialty Developing Recommendation: ACRh, ASCO, ASH, ISDA</th>
<th>First Identified: April 2013</th>
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</table>

**2020 Medicare Utilization:** 132,910

### 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

<table>
<thead>
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<th>Most Recent RUC Meeting:</th>
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<th>Tab: 26</th>
<th>Specialty Developing Recommendation: ASCO, ASH, AAFP, ACRh</th>
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**2020 Medicare Utilization:** 7,679,555

### 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

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<thead>
<tr>
<th>Most Recent RUC Meeting:</th>
<th>January 2017</th>
<th>Tab: 26</th>
<th>Specialty Developing Recommendation: ASCO, ASH, ACRh</th>
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**2020 Medicare Utilization:** 231,198
### Status Report: CMS Requests and Relativity Assessment Issues

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<tr>
<td>96375</td>
<td>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)</td>
<td>ZZZ</td>
<td>Application of On-body Injector with Subcutaneous Injection</td>
<td>CMS High Expenditure Procedural Codes2</td>
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<tr>
<td>96377</td>
<td>Application of on-body injector (includes cannula insertion) for timed subcutaneous injection</td>
<td>XXX</td>
<td>Application of On-body Injector with Subcutaneous Injection</td>
<td>should be on N/R LOI just added to track</td>
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<tr>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic</td>
<td>XXX</td>
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<td>CMS High Expenditure Procedural Codes2</td>
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<td>96375</td>
<td></td>
<td>0.10</td>
<td>Specialty Developing Recommendation: ASCO, ASH, ACMh</td>
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<td>96377</td>
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<td>Specialty Developing Recommendation: ASCO, ASH</td>
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<td>96401</td>
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<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<td>0.10</td>
<td>0.36 NA</td>
<td>NA</td>
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<td>0.17</td>
<td>0.38 NA</td>
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<td>0.21</td>
<td>1.99 NA</td>
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**Note:** The **Table** and **Issue** columns list the recommendations and issues associated with the codes. The **Screen** column indicates the screen for which the recommendation is being made. The **Global** column specifies the global status of the recommendation. The **Complete?** column indicates whether the recommendation is complete or not. The **Result** column provides the result of the Medicare utilization analysis.
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>Screen</th>
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<tr>
<td>96402</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic</td>
<td>XXX</td>
<td>Chemotherapy Administration</td>
<td>CMS High Expenditure Procedural Codes</td>
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<tr>
<td>96405</td>
<td>Chemotherapy administration; intralesional, up to and including 7 lesions</td>
<td>000</td>
<td>Chemotherapy Administration</td>
<td>CMS Request - Practice Expense Review</td>
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<tr>
<td>96406</td>
<td>Chemotherapy administration; intralesional, more than 7 lesions</td>
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<td>Chemotherapy Administration</td>
<td>CMS Request - Practice Expense Review</td>
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<tr>
<td>96409</td>
<td>Chemotherapy administration; intravenous, push technique, single or initial substance/drug</td>
<td>XXX</td>
<td>Chemotherapy Administration</td>
<td>CMS High Expenditure Procedural Codes</td>
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<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
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<tr>
<td>96402</td>
<td>January 2017</td>
<td>27</td>
<td>ASBMT, ASCO, ASH, AUA</td>
<td>July 2015</td>
<td>394,519</td>
<td>0.19</td>
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<td>96405</td>
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<td>96409</td>
<td>January 2017</td>
<td>27</td>
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</table>

**Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic**

- **Global:** XXX
- **Issue:** Chemotherapy Administration
- **Screen:** CMS High Expenditure Procedural Codes
- **Complete?** Yes

**Most Recent RUC Meeting:** January 2017
- **Tab:** 27
- **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, AUA
- **First Identified:** July 2015
- **2020 Medicare Utilization:** 394,519
- **2022 Work RVU:** 0.19
- **2022 NF PE RVU:** 0.77
- **2022 Fac PE RVU:** NA
- **Result:** Maintain

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**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
- **2020 Medicare Utilization:** 13,682
- **2022 Work RVU:** 0.52
- **2022 NF PE RVU:** 1.95
- **2022 Fac PE RVU:** 0.28
- **Result:** PE Only

---

**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
- **2020 Medicare Utilization:** 608
- **2022 Work RVU:** 0.80
- **2022 NF PE RVU:** 3.10
- **2022 Fac PE RVU:** 0.44
- **Result:** PE Only

---

**Chemotherapy administration; intravenous, push technique, single or initial substance/drug**

- **Global:** XXX
- **Issue:** Chemotherapy Administration
- **Screen:** CMS High Expenditure Procedural Codes
- **Complete?** Yes

**Most Recent RUC Meeting:** January 2017
- **Tab:** 27
- **Specialty Developing Recommendation:** ASBMT, ASCO, ASH
- **First Identified:** July 2015
- **2020 Medicare Utilization:** 65,537
- **2022 Work RVU:** 0.24
- **2022 NF PE RVU:** 2.80
- **2022 Fac PE RVU:** NA
- **Result:** Maintain

---

Tuesday, February 1, 2022
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<th>Issue</th>
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<th>Tab</th>
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<th>Medicare Utilization</th>
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<th>2022 Fac PE RVU</th>
<th>2022 NF PE RVU</th>
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<tr>
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<td>27</td>
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<td>96413</td>
<td>XXX</td>
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<td>ACRh, ASCO, ASH, ASBMT</td>
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<td>29</td>
<td>ACRh, ASCO, ASH, ASBMT</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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<th>Code</th>
<th>Description</th>
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<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>96416</td>
<td>Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump</td>
<td>XXX</td>
<td>Chemotherapy Administration</td>
<td>Codes Reported Together 75% or More-Part1</td>
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<tr>
<td>96417</td>
<td>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)</td>
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<td>96440</td>
<td>Chemotherapy administration into pleural cavity, requiring and including thoracentesis</td>
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<td>Chemotherapy Administration</td>
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</table>

### 96416
- **Most Recent RUC Meeting**: October 2010
- **Tab**: 20
- **Specialty Developing Recommendation**: ACRh, ASCO, ASH
- **First Identified**: February 2010
- **Medicare Utilization**: 26,215
- **Result**: PE Only

### 96417
- **Most Recent RUC Meeting**: January 2013
- **Tab**: 29
- **Specialty Developing Recommendation**: ACRh, ASCO, ASH, ASBMT
- **First Identified**: January 2012
- **Medicare Utilization**: 371,277
- **Result**: Maintain

### 96440
- **Most Recent RUC Meeting**: February 2008
- **Tab**: R
- **Specialty Developing Recommendation**: 
- **First Identified**: NA
- **Medicare Utilization**: 29
- **Result**: PE Only
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<td>January 2017</td>
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</table>

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.

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.

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.
## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Status Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
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<tbody>
<tr>
<td>96910</td>
<td>Photochemotherapy; tar and ultraviolet b (goeckerman treatment) or petrolatum and ultraviolet b</td>
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<td>Photo-chemotherapy</td>
<td>CMS High Expenditure Procedural Codes2</td>
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<td></td>
<td>Tab: 44 Specialty Developing Recommendation: AAD</td>
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<td>96920</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm</td>
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<td>Laser Treatment – Skin</td>
<td>CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3</td>
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<td>2020 Medicare Utilization: 79,671</td>
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<tr>
<td>96921</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm</td>
<td>000</td>
<td>Laser Treatment – Skin</td>
<td>High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3</td>
<td>No</td>
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<td>Most Recent RUC Meeting: January 2022</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

| CMS Request ID | Description                                                                 | Global | Issue            | Screen                                | Complete? | RUC Recommendation | Tab | Most Recent RUC Meeting | Specialty Developing Recommendation | First Identified | 2020 Medicare Utilization | 2022 Work RVU | 2022 NF PE RVU | 2022 Fac PE RVU |
|----------------|------------------------------------------------------------------------------|--------|------------------|---------------------------------------|-----------|---------------------|-----|------------------------|------------------------|------------------|--------------------------|----------------|----------------|----------------|----------------|
| 96922          | Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm   | 000    | Laser Treatment – Skin | High Volume Growth 1 / CMS Fastest Growing / CPT Assistant Analysis | No        | Survey 2.10          | 20  | January 2022           | AAD                    | October 2008     | 11,568                   | 2.10           | 4.75           | 1.19           |
| 96X70          | Referred to CPT                                                              |        | Caregiver Behavior Management Training | RUC Flag for Review                    | No        | Review action plan  | 11  | April 2021             | AACAP, AND, APA (psychology) | April 2021      |                             |                             |                             |               |
| 96X71          | Referred to CPT                                                              |        | Caregiver Behavior Management Training | RUC Flag for Review                    | No        | Review action plan  | 11  | April 2021             |                                      | April 2021      |                             |                             |                             |               |
| 97001          | Physical therapy evaluation                                                 |        | Physical Medicine and Rehabilitation Workgroup | CMS High Expenditure Procedural Codes 1 | Yes       | Deleted from CPT    | 17  | October 2015           |                                      | September 2011   |                             |                             |                             |               |

RUC Recommendation: Survey 2.10

Referral to CPT: No

Referral to CPT Assist: Yes

Published in CPT Asst: Sep 2016

Result: Maintain

RUC Recommendation: Survey 2.10

Referral to CPT: Yes

Referral to CPT Assist: Yes

Published in CPT Asst: Sep 2016

Result: Not part of RAW

RUC Recommendation: Survey 2.10

Referral to CPT: Yes

Referral to CPT Assist: Yes

Published in CPT Asst: Sep 2016

Result: Not part of RAW

RUC Recommendation: Survey 2.10

Referral to CPT: Yes

Referral to CPT Assist: Yes

Published in CPT Asst: Sep 2016

Result: Deleted from CPT

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## Status Report: CMS Requests and Relativity Assessment Issues

|--------|---------------------------|-------------------------------------------------------------|------------------------------------------------|-----------|------------------------
| 97002  | Physical therapy re-evaluation | First Identified: February 2015 2020 Medicare Utilization: 2022 Work RVU: 2022 NF PE RVU: 2022 Fac PE RVU: | Referred to CPT February 2015 Published in CPT Asst: | Yes       | Yes
|        |                           | RUC Recommendation: Deleted from CPT                         |                                                  |           |                       |
|        |                           | RUC Recommendation: Deleted from CPT                         |                                                  |           |                       |
| 97004  | Occupational therapy re-evaluation | First Identified: February 2015 2020 Medicare Utilization: 2022 Work RVU: 2022 NF PE RVU: 2022 Fac PE RVU: | Referred to CPT February 2015 Published in CPT Asst: | Yes       | Yes
|        |                           | RUC Recommendation: Deleted from CPT                         |                                                  |           |                       |
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>Issue</th>
<th>Screen</th>
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</tr>
</thead>
<tbody>
<tr>
<td>97010</td>
<td>Application of a modality to 1 or more areas; hot or cold packs</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** April 2017

**RUC Recommendation:** No specialty society interest

**Tab:** 41

**Specialty Developing Recommendation:** No Interest

**First Identified:** April 2016

**2020 Medicare Utilization:**

**2022 Work RVU:** 0.06

**2022 NF PE RVU:** 0.11

**2022 Fac PE RVU:** NA

**Referred to CPT**

**Results:** Maintain

**Published in CPT Asst:**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
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<th>Screen</th>
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<tbody>
<tr>
<td>97012</td>
<td>Application of a modality to 1 or more areas; traction, mechanical</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** January 2017

**RUC Recommendation:** APTA

**Tab:** 29

**Specialty Developing Recommendation:** APTA

**First Identified:** April 2016

**2020 Medicare Utilization:** 417,188

**2022 Work RVU:** 0.25

**2022 NF PE RVU:** 0.16

**2022 Fac PE RVU:** NA

**Referred to CPT**

**Results:** Maintain

**Published in CPT Asst:**

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<table>
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>97014</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (unattended)</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** January 2017

**RUC Recommendation:** APTA

**Tab:** 29

**Specialty Developing Recommendation:** APTA

**First Identified:** April 2016

**2020 Medicare Utilization:**

**2022 Work RVU:** 0.18

**2022 NF PE RVU:** 0.18

**2022 Fac PE RVU:** NA

**Referred to CPT**

**Results:** Maintain

**Published in CPT Asst:**
<table>
<thead>
<tr>
<th>Application of a modality to 1 or more areas; vasopneumatic devices</th>
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<tr>
<td><strong>Global</strong>: XXX</td>
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<td><strong>Most Recent RUC Meeting</strong>: January 2017</td>
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<td><strong>RUC Recommendation</strong>: 0.18</td>
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</table>

<table>
<thead>
<tr>
<th>Application of a modality to 1 or more areas; paraffin bath</th>
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<tbody>
<tr>
<td><strong>Global</strong>: XXX</td>
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<tr>
<td><strong>Most Recent RUC Meeting</strong>: January 2017</td>
</tr>
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<td><strong>RUC Recommendation</strong>: 0.06</td>
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</table>

<table>
<thead>
<tr>
<th>Application of a modality to 1 or more areas; whirlpool</th>
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<tbody>
<tr>
<td><strong>Global</strong>: XXX</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting</strong>: January 2017</td>
</tr>
<tr>
<td><strong>RUC Recommendation</strong>: 0.17</td>
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</table>
## Status Report: CMS Requests and Relativity Assessment Issues

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</thead>
<tbody>
<tr>
<td>97032</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
<td>0.25</td>
<td>January 2017</td>
<td>29</td>
<td>APTA</td>
<td>July 2015</td>
<td>687,061</td>
<td>0.25</td>
<td>0.17</td>
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<tr>
<td>97033</td>
<td>Application of a modality to 1 or more areas; iontophoresis, each 15 minutes</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Yes</td>
<td>0.26</td>
<td>January 2017</td>
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<td>APTA</td>
<td>April 2016</td>
<td>39,200</td>
<td>0.26</td>
<td>0.31</td>
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<tr>
<td>97034</td>
<td>Application of a modality to 1 or more areas; contrast baths, each 15 minutes</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>Yes</td>
<td>0.21</td>
<td>January 2017</td>
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<td>APTA, AOTA</td>
<td>April 2016</td>
<td>6,669</td>
<td>0.21</td>
<td>0.21</td>
<td>NA</td>
<td>Maintain</td>
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</table>
## Status Report: CMS Requests and Relativity Assessment Issues

### 97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes

<table>
<thead>
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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Modalities</td>
<td>Low Value-High Volume / CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** January 2017  
**Tab Number:** 29  
**Specialty Developing Recommendation:** APTA  
**First Identified:** October 2020  
**2020 Medicare Utilization:** 1,417,772  
**2022 Work RVU:** 0.21  
**2022 NF PE RVU:** 0.20  
**2022 Fac PE RVU:** NA

RUC Recommendation: 0.21  
Referred to CPT  
Published in CPT Asst:  
Result: Maintain

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### 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<table>
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<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Therapeutic</td>
<td>Codes Reported Together 75% or More / MPC List / CMS High Expenditure Procedural Codes2</td>
<td>Yes</td>
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</table>

**Most Recent RUC Meeting:** January 2017  
**Tab Number:** 29  
**Specialty Developing Recommendation:** AOTA, APTA  
**First Identified:** February 2010  
**2020 Medicare Utilization:** 48,673,226  
**2022 Work RVU:** 0.45  
**2022 NF PE RVU:** 0.40  
**2022 Fac PE RVU:** NA

RUC Recommendation: 0.45  
Referred to CPT  
Published in CPT Asst:  
Result: Maintain

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### 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

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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Therapeutic</td>
<td>CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2</td>
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**Most Recent RUC Meeting:** January 2017  
**Tab Number:** 29  
**Specialty Developing Recommendation:** APTA, AOTA  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 16,195,152  
**2022 Work RVU:** 0.50  
**2022 NF PE RVU:** 0.49  
**2022 Fac PE RVU:** NA

RUC Recommendation: 0.50  
Referred to CPT  
Published in CPT Asst:  
Result: Increase

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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>Issue</th>
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<th>Complete?</th>
<th>Work RVU</th>
<th>NF PE RVU</th>
<th>Fac PE RVU</th>
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</thead>
<tbody>
<tr>
<td>97113</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Therapeutic</td>
<td>CMS High Expenditure Procedural Codes 2</td>
<td>Yes</td>
<td>0.48</td>
<td>0.59</td>
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<td>Tab: 29</td>
<td>First Identiied: July 2015</td>
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<td></td>
<td>RUC Recommendation: 0.48</td>
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<td>Referred to CPT Asst Published in CPT Asst:</td>
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</table>

| 97116  | Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) | XXX    | Physical Medicine and Rehabilitation Services - Therapeutic          | Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes 2 | Yes       | 0.45     | 0.40      | NA         |
|        | Most Recent RUC Meeting: January 2017                                       | Tab: 29| First Identiied: February 2010                                      | Referred to CPT                                                        |            |          |           |            |
|        | RUC Recommendation: 0.45                                                     |        |                                                                      |                                                                        |            |          |           |            |
|        | 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 | XXX    | Cognitive Function Intervention                                       | High Volume Growth 3                                                  | Yes       | 2022 Work RVU: | 2022 NF PE RVU: | 2022 Fac PE RVU: |
|        | Most Recent RUC Meeting: January 2017                                       | Tab: 29| First Identiied: January 2017                                       | Referred to CPT                                                        |            |          |           |            |
|        | Specialty Developing Recommendation:                                       |        | 2020 Medicare Utilization:                                           | Result: Decrease                                                      |            |          |           |            |
|        | RUC Recommendation: 1.50                                                     |        |                                                                      |                                                                        |            |          |           |            |
|        | 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

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<thead>
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<th>Global:</th>
<th>Issue:</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Therapeutic</td>
<td>CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2</td>
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**Most Recent RUC Meeting:** January 2017  
**Tab:** 29  
**Specialty Developing Recommendation:** APTA  
**First Identified:** September 2011  
**2020 Medicare Utilization:** 22,945,736  
**2022 Work RVU:** 0.43  
**2022 NF PE RVU:** 0.35  
**2022 Fac PE RVU:** NA  
**Result:** Maintain  

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

### 97150 Therapeutic procedure(s), group (2 or more individuals)

<table>
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<th>Global:</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services - Therapeutic</td>
<td>CMS-Other - Utilization over 500,000</td>
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</table>

**Most Recent RUC Meeting:** January 2012  
**Tab:** 29  
**Specialty Developing Recommendation:** APTA  
**First Identified:** April 2011  
**2020 Medicare Utilization:** 999,305  
**2022 Work RVU:** 0.29  
**2022 NF PE RVU:** 0.22  
**2022 Fac PE RVU:** NA  
**Result:** Increase  

**Referred to CPT**  
**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.

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<th>Global:</th>
<th>Issue:</th>
<th>Screen:</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>CMS High Expenditure Procedural Codes1</td>
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</table>

**Most Recent RUC Meeting:** October 2015  
**Tab:** 17  
**Specialty Developing Recommendation:** AOTA, APTA  
**First Identified:** February 2015  
**2020 Medicare Utilization:** 1,188,088  
**2022 Work RVU:** 1.54  
**2022 NF PE RVU:** 1.35  
**2022 Fac PE RVU:** NA  
**Result:** Decrease  

**Referred to CPT**  
**February 2015**  
**Referred to CPT Asst**  
**Published in CPT Asst:**

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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
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<th>Complete?</th>
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<tbody>
<tr>
<td>97162</td>
<td>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.</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>CMS High Expenditure Procedural Codes1</td>
<td>Yes</td>
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| 2022 Work RVU: | 1.54 | 2022 NF PE RVU: | 1.35 |

| RUC Recommendation: | 1.18 | Referred to CPT: February 2015 | Published in CPT Asst: |

| Result: | Decrease |

| 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. | XXX | Physical Medicine and Rehabilitation Services | CMS High Expenditure Procedural Codes1 | Yes |


| 2022 Work RVU: | 1.54 | 2022 NF PE RVU: | 1.35 |

| RUC Recommendation: | 1.50 | Referred to CPT: February 2015 | Published in CPT Asst: |

| Result: | Maintain |
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<tr>
<th>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.</th>
<th>Global: XXX</th>
<th>Issue: Physical Medicine and Rehabilitation Services</th>
<th>Screen: CMS High Expenditure Procedural Codes1</th>
<th>Complete? Yes</th>
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<tr>
<td>Tab: 17</td>
<td>Specialty Developing Recommendation: AOTA, APTA</td>
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<td>First Identified: February 2015</td>
<td>2020 Medicare Utilization: 443,064</td>
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<td>Published in CPT Asst:</td>
<td>2022 Fac PE RVU: NA</td>
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</table>

### 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 |
| Tab: 17 | Specialty Developing Recommendation: AOTA, APTA |
| First Identified: February 2015 | 2020 Medicare Utilization: 124,556 |
| RUC Recommendation: 0.88 | 2022 Work RVU: 1.54 |
| Referred to CPT February 2015 | 2022 NF PE RVU: 1.37 |
| Published in CPT Asst: | 2022 Fac PE RVU: NA |

**Result:** Increase
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
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<th>Complete?</th>
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<tr>
<td>97166</td>
<td>Occupational therapy evaluation, moderate complexity, requiring these</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>CMS High Expenditure Procedural Codes</td>
<td>Yes</td>
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<tr>
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<td>components: an occupational profile and medical and therapy history, which</td>
<td>Issue</td>
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<td>includes an expanded review of medical and/or therapy records and additional</td>
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<td>review of physical, cognitive, or psychosocial history related to current</td>
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<td>functional performance; an assessment(s) that identifies 3-5 performance</td>
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<td>deficits (ie, relating to physical, cognitive, or psychosocial skills)</td>
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<td></td>
<td>that result in activity limitations and/or participation restrictions; and</td>
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<td>clinical decision making of moderate analytic complexity, which includes</td>
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<td>an analysis of the occupational profile, analysis of data from detailed</td>
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<td>assessment(s), and consideration of several treatment options. patient</td>
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<td>may present with comorbidities that affect occupational performance.</td>
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<td>minimal to moderate modification of tasks or assistance (eg, physical or</td>
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<td>verbal) with assessment(s) is necessary to enable patient to complete</td>
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<td></td>
<td>evaluation component. typically, 45 minutes are spent face-to-face with</td>
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<td>the patient and/or family.</td>
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<td>97167</td>
<td>Occupational therapy evaluation, high complexity, requiring these</td>
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<td>components: an occupational profile and medical and therapy history, which</td>
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<td>includes review of medical and/or therapy records and extensive additional</td>
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<td>review of physical, cognitive, or psychosocial history related to current</td>
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<td>functional performance; an assessment(s) that identifies 5 or more</td>
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<td>performance deficits (ie, relating to physical, cognitive, or psychosocial</td>
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<td>skills) that result in activity limitations and/or participation</td>
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<td>restrictions; and clinical decision making of high analytic complexity,</td>
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<td>which includes an analysis of the patient profile, analysis of data</td>
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<td>from comprehensive assessment(s), and consideration of multiple</td>
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<td>treatment options. patient presents with comorbidities that affect</td>
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<td>occupational performance. significant modification of tasks or assistance</td>
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<td>(eg, physical or verbal) with assessment(s) is necessary to enable</td>
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<td>patient to complete evaluation component. typically, 60 minutes are</td>
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<td>spent face-to-face with the patient and/or family.</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>97168</td>
<td>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.</td>
<td>XXX</td>
<td>Physical Medicine and Rehabilitation Services</td>
<td>CMS High Expenditure Procedural Codes1</td>
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**Most Recent RUC Meeting:** October 2015  
**Tab:** 17  
**Specialty Developing Recommendation:** AOTA, APTA  
**First Identified:** February 2015  
**2020 Medicare Utilization:** 28,565  
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**Referred to CPT Asst Published in CPT Asst:**

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<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes</td>
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**Most Recent RUC Meeting:** January 2017  
**Tab:** 29  
**Specialty Developing Recommendation:** APTA, AOTA  
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**2020 Medicare Utilization:** 17,002,856  
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**Referred to CPT Asst Published in CPT Asst:**

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<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes</td>
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<td>Cognitive Function Intervention</td>
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**Most Recent RUC Meeting:** January 2017  
**Tab:** 29  
**Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology)  
**First Identified:** April 2013  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Referred to CPT Asst Published in CPT Asst:**

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Tuesday, February 1, 2022  
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### 97533: Sensory Integrative Techniques

- **Issue:** 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

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### 97535: Self-Care/Home Management Training

- **Issue:** 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

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### 97537: Community/Work Reintegration Training

- **Issue:** 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

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<td>97542</td>
<td>Wheelchair management (e.g., assessment, fitting, training), each 15 minutes</td>
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<td>97597</td>
<td>Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., 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</td>
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<td>97598</td>
<td>Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., 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)</td>
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### Status Report: CMS Requests and Relativity Assessment Issues

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<td>utilizing disposable, non-durable medical equipment including provision of</td>
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<td>exudate management collection system, topical application(s), wound</td>
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<td>assessment, and instructions for ongoing care, per session; total wound(s)</td>
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<td>surface area less than or equal to 50 square centimeters</td>
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<td>97608</td>
<td>Negative pressure wound therapy, (eg, vacuum assisted drainage collection),</td>
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<td>utilizing disposable, non-durable medical equipment including provision of</td>
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<td>exudate management collection system, topical application(s), wound</td>
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<td>assessment, and instructions for ongoing care, per session; total wound(s)</td>
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<td>surface area greater than 50 square centimeters</td>
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<td>Low frequency, non-contact, non-thermal ultrasound, including topical</td>
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<td>application(s), when performed, wound assessment, and instruction(s) for</td>
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<td>ongoing care, per day</td>
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**Tuesday, February 1, 2022**

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**Status Report: CMS Requests and Relativity Assessment Issues**

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<td>97755</td>
<td>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</td>
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| 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 |             | Orthotic Management and Prosthetic Training | Physical Medicine and Rehabilitation Services | Complete? | Yes |
|        | **Most Recent RUC Meeting:** January 2017                                                                                                                                         |             |                                           |                             |           |     |
|        | **Tab:** 29 | **Specialty Developing Recommendation:** APTA, AOTA | **First Identified:** April 2016 | **2020 Medicare Utilization:** 47,325 | **2022 Work RVU:** 0.50 | **2022 NF PE RVU:** 0.92 | **2022 Fac PE RVU:** NA | **Complete?** | Yes |
|        | **RUC Recommendation:** 0.50 | **Referred to CPT** | **Published in CPT Asst:** | **Result:** Increase | | | | | |

<p>| 97761  | Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes                                                                 |             | Orthotic Management and Prosthetic Training | Physical Medicine and Rehabilitation Services | Complete? | Yes |
|        | <strong>Most Recent RUC Meeting:</strong> January 2017                                                                                                                                         |             |                                           |                             |           |     |
|        | <strong>Tab:</strong> 29 | <strong>Specialty Developing Recommendation:</strong> APTA | <strong>First Identified:</strong> April 2016 | <strong>2020 Medicare Utilization:</strong> 3,036 | <strong>2022 Work RVU:</strong> 0.50 | <strong>2022 NF PE RVU:</strong> 0.71 | <strong>2022 Fac PE RVU:</strong> NA | <strong>Complete?</strong> | Yes |
|        | <strong>RUC Recommendation:</strong> 0.50 | <strong>Referred to CPT</strong> | <strong>Published in CPT Asst:</strong> | <strong>Result:</strong> Increase | | | | | |</p>
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<td>97762</td>
<td>Checkout for orthotic/prosthetic use, established patient, each 15 minutes</td>
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<tr>
<td>97763</td>
<td>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</td>
<td>XXX</td>
<td>Orthotic Management and Prosthetic Training</td>
<td>Physical Medicine and Rehabilitation Services</td>
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<tr>
<td>97802</td>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
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<td>Medical Nutrition Therapy</td>
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Tuesday, February 1, 2022
### Status Report: CMS Requests and Relativity Assessment Issues

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<td>Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
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| 98929  | Osteopathic manipulative treatment (omt); 9-10 body regions involved | 0.00   | Osteopathic Manipulative Treatment | Harvard Valued - Utilization over 100,000 | Yes      |       |       |       |       |
|        | Most Recent RUC Meeting: February 2011 Tab: 34   |        |                | 2022 Work RVU: 1.46                        |          |       |       |       |       |
|        | Specialty Developing Recommendation: AOA         |        |                | 2022 NF PE RVU: 0.94                       |          |       |       |       |       |
|        | RUC Recommendation: 1.50                        |        |                | 2022 Fac PE RVU: 0.52                      |          |       |       |       |       |
|        | First Identified: February 2010                  |        |                | Referred to CPT                             |          |       |       |       |       |
|        | Medicare Utilization: 62,738                      |        |                | Published in CPT Asst                        |          |       |       |       |       |
|        | Result: Increase                                 |        |                |                                             |          |       |       |       |       |

| 98940  | Chiropractic manipulative treatment (cmt); spinal, 1-2 regions | 0.00   | Chiropractic Manipulative Treatment | CMS High Expenditure Procedural Codes1 | Yes      |       |       |       |       |
|        | Most Recent RUC Meeting: October 2012 Tab: 25     |        |                | 2022 Work RVU: 0.46                        |          |       |       |       |       |
|        | Specialty Developing Recommendation: ACA          |        |                | 2022 NF PE RVU: 0.34                       |          |       |       |       |       |
|        | RUC Recommendation: 0.46                         |        |                | 2022 Fac PE RVU: 0.17                      |          |       |       |       |       |
|        | First Identified: September 2011                 |        |                | Referred to CPT                             |          |       |       |       |       |
|        | Medicare Utilization: 4,333,649                   |        |                | Published in CPT Asst                        |          |       |       |       |       |
|        | Result: Increase                                 |        |                |                                             |          |       |       |       |       |

<p>| 98941  | Chiropractic manipulative treatment (cmt); spinal, 3-4 regions | 0.00   | Chiropractic Manipulative Treatment | CMS High Expenditure Procedural Codes1 | Yes      |       |       |       |       |
|        | Most Recent RUC Meeting: October 2012 Tab: 25     |        |                | 2022 Work RVU: 0.71                        |          |       |       |       |       |
|        | Specialty Developing Recommendation: ACA          |        |                | 2022 NF PE RVU: 0.44                       |          |       |       |       |       |
|        | RUC Recommendation: 0.71                         |        |                | 2022 Fac PE RVU: 0.27                      |          |       |       |       |       |
|        | First Identified: September 2011                 |        |                | Referred to CPT                             |          |       |       |       |       |
|        | Medicare Utilization: 11,589,611                  |        |                | Published in CPT Asst                        |          |       |       |       |       |
|        | Result: Increase                                 |        |                |                                             |          |       |       |       |       |</p>
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<td>Chiropractic manipulative treatment (cmt); extraspinal, 1 or more regions</td>
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## Status Report: CMS Requests and Relativity Assessment Issues

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Tuesday, February 1, 2022
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<tr>
<td>99151</td>
<td>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</td>
<td>XXX</td>
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**Moderate Sedation Services**
- AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI

**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  
**2020 Medicare Utilization:**
- Work RVU: 0.50  
- NF PE RVU: 1.52  
- Fac PE RVU: 0.19

**RUC Recommendation:** 0.50  
**Result:** Maintain

**Referred to CPT**
- 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**

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<th>Issue:</th>
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<th>Screen:</th>
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## 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**

<table>
<thead>
<tr>
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# 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

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RUC Recommendation: Referred to CPT  
Referred to CPT Asst: Published in CPT Asst:  
Result: Maintain

## 99174  Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report

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RUC Recommendation: Referred to CPT  
Referred to CPT Asst: Published in CPT Asst:  
Result: PE Only

## 99177  Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis

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RUC Recommendation: Referred to CPT  
Referred to CPT Asst: Published in CPT Asst:  
Result: PE Only

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**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

**2020 Medicare Utilization:** 325,694

**2022 Work RVU:** 2.11

**2022 NF PE RVU:** 0.78

**2022 Fac PE RVU:** 0.78

**RUC Recommendation:** 2.11

**Result:** Decrease

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst:**

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**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, ACP

**First Identified:** June 2017

**2020 Medicare Utilization:** 51,623

**2022 Work RVU:** 0.48

**2022 NF PE RVU:** NA

**2022 Fac PE RVU:** 0.11

**RUC Recommendation:** 0.48

**Result:** Increase

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst:**

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**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, ACP

**First Identified:** June 2017

**2020 Medicare Utilization:** 283,817

**2022 Work RVU:** 0.93

**2022 NF PE RVU:** NA

**2022 Fac PE RVU:** 0.21

**RUC Recommendation:** 0.93

**Result:** Increase

**Referred to CPT**

**Referred to CPT Asst**

**Published in CPT Asst:**

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### 99283 - ED Visits

**Status Report: CMS Requests and Relativity Assessment Issues**

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<td>CMS Request - Final Rule for 2018</td>
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**RUC Recommendation:**

- **First Identified:** June 2017
- **2020 Medicare Utilization:** 1,984,076
- **2022 Work RVU:** 1.60
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 0.33

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

**Result:** Increase

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**Description:**

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.

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### 99284 - ED Visits

**Status Report: CMS Requests and Relativity Assessment Issues**

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<td>XXX</td>
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**RUC Recommendation:**

- **First Identified:** June 2017
- **2020 Medicare Utilization:** 4,006,675
- **2022 Work RVU:** 2.74
- **2022 NF PE RVU:** NA
- **2022 Fac PE RVU:** 0.54

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

**Result:** Increase

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**Description:**

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.
**Status Report: CMS Requests and Relativity Assessment Issues**

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<td>99285</td>
<td>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.</td>
<td>XXX</td>
<td>ED Visits</td>
<td>CMS Request - Final Rule for 2018</td>
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**Most Recent RUC Meeting:** April 2018  
**Tab:** 29  
**Specialty Developing Recommendation:** AAP, ACEP  
**First Identified:** June 2017  
**2020 Medicare Utilization:** 9,263,820  
**2022 Work RVU:** 4.00  
**2022 NF PE RVU:** NA  
**2022 Fac PE RVU:** 0.75  
**Result:** Maintain

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<td>Prolonged evaluation and management service before and/or after direct patient care; first hour</td>
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<td>Prolonged Services - Without Direct Patient Contact</td>
<td>CMS Request - Final Rule for 2020</td>
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**Most Recent RUC Meeting:** October 2021  
**Tab:** 14  
**Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRM, AGS, ANA, ASCO, ATS, CHEST, NASS, STS  
**First Identified:** November 2019  
**2020 Medicare Utilization:** 344,177  
**2022 Work RVU:** 2.10  
**2022 NF PE RVU:** 0.96  
**2022 Fac PE RVU:** 0.96  
**Result:** Decrease

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**Tuesday, February 1, 2022**  
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### Status Report: CMS Requests and Relativity Assessment Issues

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<th>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)</th>
<th>Global: ZZZ</th>
<th>Issue: Prolonged Services - Without Direct Patient Contact</th>
<th>Screen: CMS Request - Final Rule for 2020</th>
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<td><strong>Result:</strong> Decrease</td>
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<th>Code</th>
<th>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)</th>
<th>Global:</th>
<th>Issue: Home INR Monitoring</th>
<th>Screen: High Volume Growth3</th>
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<td><strong>Most Recent RUC Meeting:</strong> January 2017</td>
<td><strong>Referred to CPT Asst:</strong> Published in CPT Asst: Yes</td>
<td><strong>Referred to CPT:</strong> September 2016</td>
<td><strong>Referred to CPT:</strong> September 2016</td>
<td><strong>Result:</strong> Deleted from CPT</td>
<td><strong>RUC Recommendation:</strong> Deleted from CPT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>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)</th>
<th>Global:</th>
<th>Issue: Home INR Monitoring</th>
<th>Screen: High Volume Growth3</th>
<th>Complete?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99364</td>
<td><strong>First Identified:</strong> September 2016</td>
<td><strong>Medicare Utilization:</strong></td>
<td><strong>RUC Recommendation:</strong> 2022 Work RVU:</td>
<td><strong>2022 NF PE RVU:</strong></td>
<td><strong>2022 Fac PE RVU:</strong></td>
<td><strong>RUC Recommendation:</strong> Deleted from CPT</td>
</tr>
<tr>
<td></td>
<td><strong>Most Recent RUC Meeting:</strong> January 2017</td>
<td><strong>Referred to CPT Asst:</strong> Published in CPT Asst: Yes</td>
<td><strong>Referred to CPT:</strong> September 2016</td>
<td><strong>Referred to CPT:</strong> September 2016</td>
<td><strong>Result:</strong> Deleted from CPT</td>
<td><strong>RUC Recommendation:</strong> Deleted from CPT</td>
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</table>
Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99375</td>
<td>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.</td>
<td>XXX</td>
<td>Home Healthcare Supervision</td>
<td>CMS-Other - Utilization over 250,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Most Recent**
- [Tab: 47](#)
- Specialty Developing Recommendation: No Interest
- First Identified: April 2016

**RUC Recommendation:** RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst □ Published in CPT Asst:

**2020 Medicare Utilization:**
- 2022 Work RVU: 1.73
- 2022 NF PE RVU: 1.14
- 2022 Fac PE RVU: 0.67

**Result:** Remove from screen

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99378</td>
<td>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.</td>
<td>XXX</td>
<td>Home Healthcare Supervision</td>
<td>CMS-Other - Utilization over 250,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Most Recent**
- [Tab: 47](#)
- Specialty Developing Recommendation: No Interest
- First Identified: April 2016

**RUC Recommendation:** RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst □ Published in CPT Asst:

**2020 Medicare Utilization:**
- 2022 Work RVU: 1.73
- 2022 NF PE RVU: 1.14
- 2022 Fac PE RVU: 0.67

**Result:** Remove from screen
# Status Report: CMS Requests and Relativity Assessment Issues

## 993X0

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue: Prolonged Services - on the date of an E/M</th>
<th>Screen: CMS Request - Final Rule for 2020</th>
<th>Complete? Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent RUC Meeting: January 2022</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Developing Recommendation: AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS</td>
<td>First Identified: February 2021</td>
<td></td>
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<tr>
<td>RUC Recommendation: 0.81</td>
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<td></td>
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<tr>
<td>Referred to CPT: February 2021</td>
<td>Referred to CPT Asst: Published in CPT Asst:</td>
<td>Result: Increase</td>
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</table>

## 99415

<table>
<thead>
<tr>
<th>Global: ZZZ</th>
<th>Issue: Prolonged Services - Clinical Staff Services (PE Only)</th>
<th>Screen: CMS Request - Final Rule for 2020</th>
<th>Complete? Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent RUC Meeting: April 2021</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Developing Recommendation: AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS</td>
<td>First Identified: February 2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUC Recommendation: New PE Inputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to CPT: February 2022</td>
<td>Referred to CPT Asst: Published in CPT Asst:</td>
<td>Result: PE Only</td>
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</tbody>
</table>

## 99416

<table>
<thead>
<tr>
<th>Global: ZZZ</th>
<th>Issue: Prolonged Services - Clinical Staff Services (PE Only)</th>
<th>Screen: CMS Request - Final Rule for 2020</th>
<th>Complete? Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent RUC Meeting: April 2021</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Developing Recommendation: AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS</td>
<td>First Identified: February 2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUC Recommendation: New PE Inputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to CPT: February 2022</td>
<td>Referred to CPT Asst: Published in CPT Asst:</td>
<td>Result: PE Only</td>
<td></td>
</tr>
</tbody>
</table>
### Status Report: CMS Requests and Relativity Assessment Issues

**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)

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue: Prolonged Services - on the date of an E/M</th>
<th>Screen: CMS Request - Final Rule for 2020</th>
<th>Complete? Yes</th>
</tr>
</thead>
</table>

**Most Recent RUC Meeting:** January 2022

**Tab:** 15  
**Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

**First Identified:** November 2021

**2020 Medicare Utilization:**

| 2022 Work RVU: | 0.61 |
| 2022 NF PE RVU: | 0.27 |
| 2022 Fac PE RVU: | 0.24 |

**RUC Recommendation:** 0.61

**Referred to CPT:** February 2021

**Result:** Maintain

| Published in CPT Asst: |

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**99491**  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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue: Chronic Care Management Services</th>
<th>Screen: New and Revised Service (Not part of RAW)</th>
<th>Complete? Yes</th>
</tr>
</thead>
</table>

**Most Recent RUC Meeting:** April 2017

**Tab:** 09  
**Specialty Developing Recommendation:** AAFP, AAN, ACP, AGS

**First Identified:** NA

**2020 Medicare Utilization:**

| 2022 Work RVU: | 1.50 |
| 2022 NF PE RVU: | 0.89 |
| 2022 Fac PE RVU: | 0.64 |

**RUC Recommendation:** 1.45. Refer to CPT Assistant

**Referred to CPT**

| Published in CPT Asst: |

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### 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 | 2020 Medicare Utilization: 6,958 | 2022 Work RVU: 1.88 | 2022 NF PE RVU: 2.45 | 2022 Fac PE RVU: 0.73 |

| 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>99493</td>
<td>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.</td>
<td>XXX</td>
<td>Psychiatric Collaborative Care Management Services</td>
<td>Work Neutrality 2018</td>
<td>No</td>
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</table>

**RUC Meetings**

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
<th>2022 Work RVU</th>
<th>2022 NF PE RVU</th>
<th>2022 Fac PE RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2020</td>
<td>37</td>
<td>AACAP, AAFP, AAP, ACP, APA (psychiatry)</td>
<td>October 2019</td>
<td>23,187</td>
<td>2.05</td>
<td>2.13</td>
<td>0.82</td>
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</table>

**CPT Assemblies**

- Referred to CPT Asst
- Published in CPT Asst:
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>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.</th>
<th>Global: XXX</th>
<th>Issue: Transitional Care Management Services</th>
<th>Screen: Codes Increased by CMS Independent of RUC Review</th>
<th>Complete? No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>99495</strong></td>
<td>Referrer to CPT:</td>
<td>Survey</td>
<td>Referrer to CPT Asst:</td>
<td>Published in CPT Asst:</td>
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<tr>
<td><strong>99496</strong></td>
<td>Referrer to CPT:</td>
<td>Survey</td>
<td>Referrer to CPT Asst:</td>
<td>Published in CPT Asst:</td>
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<tr>
<td><strong>99497</strong></td>
<td>Referrer to CPT:</td>
<td>Survey</td>
<td>Referrer to CPT Asst:</td>
<td>Published in CPT Asst:</td>
</tr>
</tbody>
</table>

**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**
## Status Report: CMS Requests and Relativity Assessment Issues

### Advance Care Planning

**Global:** ZZZ  **Issue:** Advance Care Planning  **Screen:** RUC Referral to CPT Assistant  **Complete?** No

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2022</td>
<td>20</td>
<td>AAFP, AAN, ACP, ACCP, AGS, ATS</td>
<td>January 2014</td>
<td>56,902</td>
<td>No</td>
</tr>
</tbody>
</table>

**RUC Recommendation:** Survey

- **Referred to CPT**
- **Referred to CPT Asst**
- **Published in CPT Asst:** Dec 2014

### Administration of influenza virus vaccine

**Global:** XXX  **Issue:** Immunization Administration  **Screen:** CMS Request-Final Rule for 2021  **Complete?** Yes

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2021</td>
<td>19</td>
<td>AAFP, AAP, ACOG, ACP, ANA</td>
<td>July 2020</td>
<td>0.00</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**RUC Recommendation:** 0.17

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

**Result:** Maintain

### Administration of pneumococcal vaccine

**Global:** XXX  **Issue:** Immunization Administration  **Screen:** CMS Request-Final Rule for 2021  **Complete?** Yes

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting</th>
<th>Tab</th>
<th>Specialty Developing Recommendation</th>
<th>First Identified</th>
<th>2020 Medicare Utilization</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2021</td>
<td>19</td>
<td>AAFP, AAP, ACOG, ACP, ANA</td>
<td>July 2020</td>
<td>0.00</td>
<td>Yes</td>
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</table>

**RUC Recommendation:** 0.17

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

**Result:** Maintain
### Status Report: CMS Requests and Relativity Assessment Issues

#### G0010  Administration of hepatitis b vaccine

**Global:** XXX  **Issue:** Immunization Administration  **Screen:** CMS Request-Final Rule for 2021  **Complete?** Yes

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: April 2021</th>
<th>Tab: 19</th>
<th>Specialty Developing Recommendation: AAFP, AAP, ACOG, ACP, ANA</th>
<th><strong>First Identified:</strong> July 2020</th>
<th>2020 Medicare Utilization:</th>
<th><strong>Result:</strong> Maintain</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC Recommendation: 0.17</td>
<td></td>
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<tr>
<td>Referred to CPT</td>
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</table>

#### 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

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: October 2016</th>
<th>Tab: 35</th>
<th>Specialty Developing Recommendation: ACOG</th>
<th><strong>First Identified:</strong> October 2010</th>
<th>2020 Medicare Utilization: 728,456</th>
<th><strong>Result:</strong> Remove from Screen</th>
</tr>
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<tbody>
<tr>
<td>RUC Recommendation: Remove from screen</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Referred to CPT</td>
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</tbody>
</table>

#### G0102  Prostate cancer screening; digital rectal examination

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

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: January 2017</th>
<th>Tab: 30</th>
<th>Specialty Developing Recommendation:</th>
<th><strong>First Identified:</strong> October 2016</th>
<th>2020 Medicare Utilization: 29,742</th>
<th><strong>Result:</strong> Remove from screen</th>
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<tbody>
<tr>
<td>RUC Recommendation: Remove from screen</td>
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<tr>
<td>Referred to CPT</td>
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</table>

#### G0104  Colorectal cancer screening; flexible sigmoidoscopy

**Global:** 000  **Issue:** Flexible Sigmoidoscopy  **Screen:** MPC List  **Complete?** Yes

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: January 2014</th>
<th>Tab: 09</th>
<th>Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, SAGES, ACS</th>
<th><strong>First Identified:</strong> January 2014</th>
<th>2020 Medicare Utilization: 2,061</th>
<th><strong>Result:</strong> Decrease</th>
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<tbody>
<tr>
<td>RUC Recommendation: 0.84</td>
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<tr>
<td>Referred to CPT</td>
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| Published in CPT Asst: |

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<table>
<thead>
<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0105</strong> Colorectal cancer screening; colonoscopy on individual at high risk</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting</strong>: January 2014</td>
</tr>
<tr>
<td><strong>Tab</strong>: 10</td>
</tr>
<tr>
<td><strong>Specialty Developing Recommendation</strong>: AGA, ASGE, ACG, ASCRS, ACS, SAGES</td>
</tr>
<tr>
<td><strong>RUC Recommendation</strong>: 3.36</td>
</tr>
</tbody>
</table>

| **G0108** Diabetes outpatient self-management training services, individual, per 30 minutes | **Issue**: Diabetes Management Training | **Screen**: CMS-Other - Utilization over 100,000 | **Complete?**: Yes |
| **Most Recent RUC Meeting**: April 2017 | **Global**: XXX | **2020 Medicare Utilization**: 140,681 | **2022 Work RVU**: 0.90 |
| **Tab**: 41iv | **First Identified**: April 2016 | | **2022 NF PE RVU**: 0.67 |
| **Specialty Developing Recommendation**: AND | **2022 Fac PE RVU**: NA | | **Referral to CPT**: Referred to CPT Asst Published in CPT Asst: | |
| **RUC Recommendation**: 0.90 | **Result**: Maintain | | **Referral to CPT Asst**: | |

| **G0109** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes | **Issue**: Diabetes Management Training | **Screen**: CMS-Other - Utilization over 100,000 | **Complete?**: Yes |
| **Most Recent RUC Meeting**: April 2017 | **Global**: XXX | **2020 Medicare Utilization**: 39,815 | **2022 Work RVU**: 0.25 |
| **Tab**: 41iv | **First Identified**: April 2016 | | **2022 NF PE RVU**: 0.20 |
| **Specialty Developing Recommendation**: AND | **2022 Fac PE RVU**: NA | | **Referral to CPT**: Referred to CPT Asst Published in CPT Asst: | |
| **RUC Recommendation**: 0.25 | **Result**: Maintain | | **Referral to CPT Asst**: | |

| **G0121** Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk | **Issue**: Colonoscopy | **Screen**: MPC List | **Complete?**: Yes |
| **Most Recent RUC Meeting**: January 2014 | **Global**: 000 | **2020 Medicare Utilization**: 136,530 | **2022 Work RVU**: 3.26 |
| **Tab**: 10 | **First Identified**: September 2011 | | **2022 NF PE RVU**: 6.66 |
| **Specialty Developing Recommendation**: AGA, ASGE, ACG, ASCRS, ACS, SAGES | **2022 Fac PE RVU**: 1.74 | | **Referral to CPT**: Referred to CPT Asst Published in CPT Asst: | |
| **RUC Recommendation**: 3.36 | **Result**: Decrease | | **Referral to CPT Asst**: | |
Status Report: CMS Requests and Relativity Assessment Issues

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 |
| Complete? Yes | Screen: CMS-Other - Utilization over 30,000 |

| Most Recent RUC Meeting: April 2018 | Tab: 26 | Specialty Developing Recommendation: CAP |
| First Identified: October 2017 | Referred to CPT |
| 2020 Medicare Utilization: 39,175 | Published in CPT Asst: |

| RUC Recommendation: 0.42 |
| 2022 Work RVU: 0.26 |
| 2022 NF PE RVU: 0.38 |
| 2022 Fac PE RVU: 0.38 |

RUC Recommendation: 0.42

G0127  Trimming of dystrophic nails, any number

| Global: 000 | Issue: |
| Complete? Yes | Screen: CMS-Other - Utilization over 500,000 |

| Most Recent RUC Meeting: September 2011 | Tab: 51 | Specialty Developing Recommendation: APMA |
| First Identified: April 2011 | Referred to CPT |
| 2020 Medicare Utilization: 913,572 | Published in CPT Asst: |

| RUC Recommendation: Remove from screen |
| 2022 Work RVU: 0.17 |
| 2022 NF PE RVU: 0.51 |
| 2022 Fac PE RVU: 0.04 |

RUC Recommendation: 0.42

G0141  Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

| Global: XXX | Issue: Cytopathology Cervical/Vaginal |
| Complete? Yes | Screen: CMS-Other - Utilization over 30,000 |

| Most Recent RUC Meeting: April 2018 | Tab: 26 | Specialty Developing Recommendation: CAP |
| First Identified: October 2017 | Referred to CPT |
| 2020 Medicare Utilization: 2,589 | Published in CPT Asst: |

| RUC Recommendation: 0.42 |
| 2022 Work RVU: 0.26 |
| 2022 NF PE RVU: 0.38 |
| 2022 Fac PE RVU: 0.38 |

RUC Recommendation: 0.42

Result: Maintain
# Status Report: CMS Requests and Relativity Assessment Issues

## G0166  External counterpulsation, per treatment session

<table>
<thead>
<tr>
<th>Global:</th>
<th>XXX</th>
<th>Issue:</th>
<th>External Counterpulsation</th>
<th>Screen:</th>
<th>CMS-Other - Utilization over 100,000 / CMS Request - Final Rule for 2020</th>
<th>Complete?</th>
<th>Yes</th>
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</thead>
</table>

**Most Recent RUC Meeting:** October 2019  
**Tab:** 14  
**Specialty Developing Recommendation:** ACC  
**First Identified:** April 2016  
**2020 Medicare Utilization:** 57,008  
**RUC Recommendation:** 0.00 (PE Only)  
**Reflected to CPT:**  
**Published in CPT Asst:**

## G0168  Wound closure utilizing tissue adhesive(s) only

<table>
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<tr>
<th>Global:</th>
<th>000</th>
<th>Issue:</th>
<th>Wound Closure by Adhesive</th>
<th>Screen:</th>
<th>CMS 000-Day Global Typically Reported with an E/M</th>
<th>Complete?</th>
<th>Yes</th>
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</thead>
</table>

**Most Recent RUC Meeting:** April 2017  
**Tab:** 34  
**Specialty Developing Recommendation:** ACEP, AAFP  
**First Identified:** July 2016  
**2020 Medicare Utilization:** 35,030  
**RUC Recommendation:** 0.45  
**Reflected to CPT:**  
**Reflected to CPT Asst:**  
**Result:** Maintain  
**Published in CPT Asst:**

## 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

<table>
<thead>
<tr>
<th>Global:</th>
<th>XXX</th>
<th>Issue:</th>
<th>Physician Recertification</th>
<th>Screen:</th>
<th>CMS Fastest Growing / CMS-Other - Utilization over 250,000</th>
<th>Complete?</th>
<th>Yes</th>
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</thead>
</table>

**Most Recent RUC Meeting:** April 2016  
**Tab:** 47  
**Specialty Developing Recommendation:** No Interest  
**First Identified:** October 2008  
**2020 Medicare Utilization:** 770,216  
**RUC Recommendation:** RUC recommended to survey but no specialty society interest followed.  
**Reflected to CPT:**  
**Reflected to CPT Asst:**  
**Result:** Remove from screen  
**Published in CPT Asst:**

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Tuesday, February 1, 2022  
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### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>G0180</th>
<th>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</th>
<th>Global: XXX</th>
<th>Issue: Physician Recertification</th>
<th>Screen: CMS Fastest Growing / CMS-Other - Utilization over 250,000</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>RUC Recommendation: RUC recommended to survey but no specialty society interest followed.</td>
<td></td>
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<td>Referred to CPT Asst</td>
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</table>

<table>
<thead>
<tr>
<th>G0181</th>
<th>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</th>
<th>Global: XXX</th>
<th>Issue: Home Healthcare Supervision</th>
<th>Screen: CMS Fastest Growing / CMS-Other - Utilization over 250,000</th>
<th>Complete? Yes</th>
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<tr>
<td></td>
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<tr>
<td>RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.</td>
<td></td>
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<td>Referred to CPT Asst</td>
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<td>CPT Code</td>
<td>Description</td>
<td>Global</td>
<td>Issue</td>
<td>Screen</td>
<td>Complete?</td>
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<tr>
<td>G0182</td>
<td>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</td>
<td>XXX</td>
<td>Home Healthcare</td>
<td>CMS-Other - Utilization over 250,000</td>
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<td></td>
<td>Most Recent RUC Meeting: April 2016</td>
<td>Tab: 47</td>
<td>Specialty Developing</td>
<td>First Identified: April 2016</td>
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<td>2022 Fac PE RVU: NA</td>
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<td>RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.</td>
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<td>Published in CPT Asst:</td>
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<tr>
<td>G0202</td>
<td>Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed</td>
<td></td>
<td>Mammography</td>
<td>CMS Fastest Growing / CMS-Other - Utilization over 250,000</td>
<td>Yes</td>
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<td>Most Recent RUC Meeting: January 2016</td>
<td>Tab: 20</td>
<td>Specialty Developing</td>
<td>First Identified: February 2008</td>
<td>2022 Work RVU:</td>
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<tr>
<td></td>
<td>RUC Recommendation: ACR</td>
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<td>Recommendation:</td>
<td>2020 Medicare Utilization:</td>
<td>2022 NF PE RVU:</td>
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<td>Referred to CPT</td>
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<td></td>
<td></td>
<td>2022 Fac PE RVU:</td>
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<td>Referred to CPT Asst</td>
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<td>Published in CPT Asst:</td>
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<tr>
<td>G0204</td>
<td>Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral</td>
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<td>Mammography</td>
<td>CMS Fastest Growing / CMS-Other - Utilization over 250,000</td>
<td>Yes</td>
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<td>Most Recent RUC Meeting: January 2016</td>
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<td>First Identified: February 2008</td>
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<td>RUC Recommendation: ACR</td>
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<td>Recommendation:</td>
<td>2020 Medicare Utilization:</td>
<td>2022 NF PE RVU:</td>
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<td>Referred to CPT</td>
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<td>2022 Fac PE RVU:</td>
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<td>Referred to CPT Asst</td>
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<td>Published in CPT Asst:</td>
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</table>
### G0206  Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td></td>
<td>Mammography</td>
<td>CMS Fastest Growing / CMS-Other - Utilization over 250,000</td>
<td>Yes</td>
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</tbody>
</table>

**Most Recent RUC Meeting:** January 2016  
**Specialty Developing Recommendation:** ACR  
**RUC Recommendation:** Assume CMS will delete  
**First Identified:** February 2008  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:**  
**Result:** Deleted from CPT  
**Published in CPT Asst:**

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### G0237  Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)

<table>
<thead>
<tr>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>Respiratory Therapy</td>
<td>CMS Fastest Growing</td>
<td>Yes</td>
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</tbody>
</table>

**Most Recent RUC Meeting:** February 2009  
**Specialty Developing Recommendation:** ACCP/ATS  
**RUC Recommendation:** Remove from screen - RUC articulated concerns regarding claims reporting to CMS  
**First Identified:** February 2008  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:** NA  
**Result:** Remove from Screen  
**Published in CPT Asst:**

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### G0238  Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring)

<table>
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<tr>
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<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>XXX</td>
<td>Respiratory Therapy</td>
<td>CMS Fastest Growing</td>
<td>Yes</td>
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</tbody>
</table>

**Most Recent RUC Meeting:** February 2009  
**Specialty Developing Recommendation:** ACCP/ATS  
**RUC Recommendation:** Remove from screen - RUC articulated concerns regarding claims reporting to CMS  
**First Identified:** February 2008  
**2020 Medicare Utilization:**  
**2022 Work RVU:**  
**2022 NF PE RVU:**  
**2022 Fac PE RVU:** NA  
**Result:** Remove from Screen  
**Published in CPT Asst:**
## Status Report: CMS Requests and Relativity Assessment Issues

### G0248

**Description:** 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.

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: January 2017</th>
<th>Tab: 19</th>
<th>Specialty Developing Recommendation: ACC</th>
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</thead>
<tbody>
<tr>
<td>First Identified: January 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020 Medicare Utilization: 34,614</td>
<td>2022 Work RVU: 0.00</td>
<td>2022 NF PE RVU: 1.87</td>
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<td>2022 Fac PE RVU: NA</td>
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</tbody>
</table>

**RUC Recommendation:** Created Category I code, recommend CMS delete G code

**Result:** Referred to CPT September 2016

**Published in CPT Asst:** Yes

### G0249

**Description:** 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.

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: January 2017</th>
<th>Tab: 19</th>
<th>Specialty Developing Recommendation: ACC</th>
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</thead>
<tbody>
<tr>
<td>First Identified: February 2008</td>
<td></td>
<td></td>
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<tr>
<td>2020 Medicare Utilization: 1,234,315</td>
<td>2022 Work RVU: 0.00</td>
<td>2022 NF PE RVU: 1.39</td>
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<td>2022 Fac PE RVU: NA</td>
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</table>

**RUC Recommendation:** Created Category I code, recommend CMS delete G code

**Result:** Referred to CPT September 2016

**Published in CPT Asst:** Yes

### G0250

**Description:** 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.

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting: January 2017</th>
<th>Tab: 19</th>
<th>Specialty Developing Recommendation: ACC</th>
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</thead>
<tbody>
<tr>
<td>First Identified: February 2008</td>
<td></td>
<td></td>
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<tr>
<td>2020 Medicare Utilization: 167,183</td>
<td>2022 Work RVU: 0.18</td>
<td>2022 NF PE RVU: 0.05</td>
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<tr>
<td>2022 Fac PE RVU: NA</td>
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</table>

**RUC Recommendation:** Created Category I code, recommend CMS delete G code

**Result:** Referred to CPT September 2016

**Published in CPT Asst:** Yes

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## Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>G0268</td>
<td>Removal of impacted cerumen (one or both ears) by physician on same date of</td>
<td>000</td>
<td>Removal of Impacted Cerumen</td>
<td>CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M</td>
<td>Yes</td>
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<td></td>
<td>service as audiologic function testing</td>
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<td><strong>Most Recent</strong> RUC Meeting: April 2017</td>
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<td><strong>Tab:</strong> 35</td>
<td>Specialty Developing Recommendation: AAO-HNS</td>
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<td></td>
<td><strong>First Identified:</strong> October 2008</td>
<td></td>
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<tr>
<td></td>
<td><strong>2020 Medicare Utilization:</strong> 130,857</td>
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<td><strong>RUC Recommendation:</strong> 0.61</td>
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<td><strong>Result:</strong> Maintain</td>
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<td><strong>Published in CPT Asst:</strong></td>
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<table>
<thead>
<tr>
<th>Code</th>
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<th>Global</th>
<th>Issue</th>
<th>Screen</th>
<th>Complete?</th>
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<tbody>
<tr>
<td>G0270</td>
<td>Medical nutrition therapy; reassessment and subsequent intervention(s)</td>
<td>XXX</td>
<td>Medical Nutrition Therapy</td>
<td>CMS Fastest Growing</td>
<td>Yes</td>
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<tr>
<td></td>
<td>following second referral in same year for change in diagnosis, medical</td>
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<td></td>
<td>condition or treatment regimen (including additional hours needed for renal</td>
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<td>disease), individual, face to face with the patient, each 15 minutes</td>
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<td><strong>Tab:</strong> 37</td>
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<tr>
<td></td>
<td><strong>2020 Medicare Utilization:</strong> 79,202</td>
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<tbody>
<tr>
<td>G0279</td>
<td>Diagnostic digital breast tomosynthesis, unilateral or bilateral (list</td>
<td>ZZZ</td>
<td>RAW</td>
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<td>Yes</td>
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<tr>
<td></td>
<td>separately in addition to 77065 or 77066)</td>
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<td><strong>Published in CPT Asst:</strong></td>
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</table>
### Status Report: CMS Requests and Relativity Assessment Issues

#### 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 Codes

<table>
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<td>2022 Fac PE RVU:</td>
<td>NA</td>
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<tr>
<td>Result:</td>
<td>Maintain</td>
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</table>

**Referral Details:**
- Referred to CPT
- Published in CPT Asst: 

#### 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:** Counseling Visit for Lung Cancer  **Screen:** CMS-Other - Utilization over 20,000 Part1

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting:</th>
<th>January 2022</th>
<th>Tab: 20</th>
<th>Specialty Developing Recommendation:</th>
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<tr>
<td>First Identified:</td>
<td>January 2019</td>
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<td>Complete?</td>
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<td>2022 Work RVU:</td>
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<td>2022 NF PE RVU:</td>
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<td>2022 Fac PE RVU:</td>
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**Referral Details:**
- Referred to CPT
- Published in CPT Asst: 

#### G0297  Low dose ct scan (ldct) for lung cancer screening

**Global:** XXX  **Issue:** Screening CT of Thorax  **Screen:** CMS-Other - Utilization over 30,000-Part2

<table>
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<tr>
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<th>Tab: 07</th>
<th>Specialty Developing Recommendation:</th>
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<td>2022 NF PE RVU:</td>
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**Referral Details:**
- Referred to CPT
- Published in CPT Asst: 

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*Source: Tuesday, February 1, 2022*
<table>
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<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
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</table>

<table>
<thead>
<tr>
<th>G0364</th>
<th>Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service</th>
<th>Global:</th>
<th>Issue: RAW</th>
<th>Screen: CMS-Other - Utilization over 30,000</th>
<th>Complete?</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting: January 2018</td>
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<td>First Identified: October 2017</td>
<td>2020 Medicare Utilization:</td>
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<table>
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<tr>
<th>G0365</th>
<th>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)</th>
<th>Global:</th>
<th>Issue: Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity</th>
<th>Screen: CMS-Other - Utilization over 30,000</th>
<th>Complete?</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting: January 2019</td>
<td>Specialty Developing Recommendation: ACR, SIR, SVS</td>
<td>First Identified: October 2017</td>
<td>2020 Medicare Utilization:</td>
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<table>
<thead>
<tr>
<th>G0389</th>
<th>Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening</th>
<th>Global:</th>
<th>Issue: Abdominal Aorta Ultrasound Screening</th>
<th>Screen: Final Rule for 2015 / High Volume Growth4</th>
<th>Complete?</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting: October 2015</td>
<td>Specialty Developing Recommendation: ACC, ACP, ACR, SCAI, SVS</td>
<td>First Identified: July 2014</td>
<td>2020 Medicare Utilization:</td>
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</table>
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th><strong>G0396</strong></th>
<th>Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 30,000</th>
<th>Complete? No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2018</td>
<td><strong>Tab:</strong> 31</td>
<td>Specialty Developing Recommendation: AAFP, ASA, ASAM</td>
<td><strong>First Identified:</strong> October 2017</td>
<td>2020 Medicare Utilization: 50,764</td>
<td>2022 Work RVU: 0.65</td>
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<tr>
<td><strong>RUC Recommendation:</strong> Refer to CPT</td>
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<table>
<thead>
<tr>
<th><strong>G0399</strong></th>
<th>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</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: High Volume Growth5</th>
<th>Complete? Yes</th>
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<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2019</td>
<td><strong>Tab:</strong> 37</td>
<td>Specialty Developing Recommendation:</td>
<td><strong>First Identified:</strong> October 2018</td>
<td>2020 Medicare Utilization: 106,622</td>
<td>2022 Work RVU: 0.00</td>
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<tr>
<td><strong>RUC Recommendation:</strong> CMS delete</td>
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</table>

<table>
<thead>
<tr>
<th><strong>G0402</strong></th>
<th>Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 100,000</th>
<th>Complete? Yes</th>
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</thead>
<tbody>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> October 2016</td>
<td><strong>Tab:</strong> 35</td>
<td>Specialty Developing Recommendation: No Specialty Society Interest</td>
<td><strong>First Identified:</strong> April 2016</td>
<td>2020 Medicare Utilization: 484,018</td>
<td>2022 Work RVU: 2.60</td>
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<tr>
<td><strong>RUC Recommendation:</strong> RUC recommended to survey but no specialty society interest followed.</td>
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<td>Maintain</td>
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**Initial Preventive Exam**

- **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
- **2020 Medicare Utilization:** 484,018
- **2022 Work RVU:** 2.60
- **2022 NF PE RVU:** 2.13
- **2022 Fac PE RVU:** 1.13
- **Result:** Maintain

---

**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 Growth 5 |
- **Complete?** Yes

- **Most Recent RUC Meeting:** January 2019
- **Tab:** 37
- **Specialty Developing Recommendation:** |
- **First Identified:** October 2018
- **2020 Medicare Utilization:** 106,622
- **2022 Work RVU:** 0.00
- **2022 NF PE RVU:** 0.00
- **2022 Fac PE RVU:** NA
- **Result:** Deleted from CPT

---

**Alcohol and/or Substance 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
- **2020 Medicare Utilization:** 50,764
- **2022 Work RVU:** 0.65
- **2022 NF PE RVU:** 0.34
- **2022 Fac PE RVU:** 0.25
- **Result:** | 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

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue: EKG for Initial Preventive Exam</th>
<th>Screen: CMS-Other - Utilization over 100,000</th>
<th>Complete?</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>RUC Recommendation: RUC recommended to survey but no specialty society interest followed.</td>
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<tr>
<td>Referred to CPT</td>
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<td>Published in CPT Asst:</td>
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### G0407  Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part2</th>
<th>Complete?</th>
<th>No</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting: April 2021</td>
<td>Tab: 24</td>
<td>Specialty Developing Recommendation: AAN, ANA, APA (psychiatry)</td>
<td>First Identified: October 2020</td>
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</tr>
<tr>
<td>RUC Recommendation: Review action plan</td>
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<td>Referred to CPT</td>
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</table>

### G0408  Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part2</th>
<th>Complete?</th>
<th>No</th>
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<tbody>
<tr>
<td>Most Recent RUC Meeting: April 2021</td>
<td>Tab: 24</td>
<td>Specialty Developing Recommendation: AAN, ANA, APA (psychiatry)</td>
<td>First Identified: October 2020</td>
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<tr>
<td>RUC Recommendation: Review action plan</td>
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<td>Referred to CPT</td>
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<td>Published in CPT Asst:</td>
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<tr>
<td>G0416</td>
<td>Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method</td>
<td>Global: XXX</td>
<td>Issue: Prostate Biopsy - Pathology</td>
<td>Screen: Final Rule for 2015</td>
</tr>
<tr>
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<td>-------------</td>
<td>---------------------------------</td>
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<tr>
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<table>
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<tr>
<th>G0422</th>
<th>Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part2</th>
<th>Complete?</th>
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<table>
<thead>
<tr>
<th>G0423</th>
<th>Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session</th>
<th>Global: XXX</th>
<th>Issue:</th>
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<table>
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<tr>
<th>G0436</th>
<th>Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes</th>
<th>Global: XXX</th>
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<th>Screen: CMS-Other - Utilization over 100,000</th>
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</table>
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<tr>
<th>G0438</th>
<th>Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit</th>
<th>Global: XXX</th>
<th>Issue: RAW</th>
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<table>
<thead>
<tr>
<th>G0439</th>
<th>Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit</th>
<th>Global: XXX</th>
<th>Issue: RAW</th>
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<table>
<thead>
<tr>
<th>G0442</th>
<th>Annual alcohol misuse screening, 15 minutes</th>
<th>Global: XXX</th>
<th>Issue: Annual Alcohol Screening</th>
<th>Screen: CMS-Other - Utilization over 100,000</th>
<th>Complete?</th>
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<tr>
<td>Most Recent RUC Meeting: October 2016</td>
<td>Tab: 35</td>
<td>Specialty Developing Recommendation: No Specialty Society Interest</td>
<td>First Identified: April 2016</td>
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</table>
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
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<th>G0444</th>
<th>Annual depression screening, 15 minutes</th>
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<tr>
<td><strong>Issue:</strong></td>
<td>Annual Depression Screening</td>
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<td><strong>Screen:</strong></td>
<td>CMS-Other - Utilization over 100,000</td>
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<td><strong>Complete?</strong></td>
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<td><strong>Most Recent RUC Meeting:</strong></td>
<td>October 2016</td>
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<td><strong>Tab:</strong></td>
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<td><strong>First Identified:</strong></td>
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<td><strong>2020 Medicare Utilization:</strong></td>
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<td><strong>2022 Work RVU:</strong></td>
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<td><strong>2022 NF PE RVU:</strong></td>
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<td><strong>2022 Fac PE RVU:</strong></td>
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<td>Published in CPT Asst:</td>
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<table>
<thead>
<tr>
<th>G0446</th>
<th>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</th>
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<tbody>
<tr>
<td><strong>Global:</strong></td>
<td>XXX</td>
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<tr>
<td><strong>Issue:</strong></td>
<td>Intensive Behavioral Therapy for Cardiovascular Disease</td>
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<tr>
<td><strong>Screen:</strong></td>
<td>CMS-Other - Utilization over 30,000</td>
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<tr>
<td><strong>Complete?</strong></td>
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<td><strong>Tab:</strong></td>
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<tr>
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<td><strong>First Identified:</strong></td>
<td>October 2017</td>
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<tr>
<td><strong>RUC Recommendation:</strong></td>
<td>Survey, but no specialty interest, so no recommendation.</td>
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<table>
<thead>
<tr>
<th>G0447</th>
<th>Face-to-face behavioral counseling for obesity, 15 minutes</th>
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<tbody>
<tr>
<td><strong>Global:</strong></td>
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<tr>
<td><strong>Issue:</strong></td>
<td>Behavioral Counseling for Obesity</td>
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<td><strong>Tab:</strong></td>
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<tr>
<td><strong>Specialty Developing Recommendation:</strong></td>
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<tr>
<td><strong>First Identified:</strong></td>
<td>April 2016</td>
</tr>
<tr>
<td><strong>2020 Medicare Utilization:</strong></td>
<td>280,549</td>
</tr>
<tr>
<td><strong>2022 Work RVU:</strong></td>
<td>0.45</td>
</tr>
<tr>
<td><strong>2022 NF PE RVU:</strong></td>
<td>0.28</td>
</tr>
<tr>
<td><strong>2022 Fac PE RVU:</strong></td>
<td>0.19</td>
</tr>
<tr>
<td><strong>RUC Recommendation:</strong></td>
<td>RUC recommended to survey but no specialty society interest followed.</td>
</tr>
<tr>
<td><strong>Result:</strong></td>
<td>Maintain</td>
</tr>
<tr>
<td><strong>Referred to CPT Asst</strong></td>
<td>Published in CPT Asst:</td>
</tr>
<tr>
<td>G0452</td>
<td>Molecular pathology procedure; physician interpretation and report</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Most Recent</td>
<td>Tab: 13</td>
</tr>
<tr>
<td>RUC Recommendation:</td>
<td>0.93</td>
</tr>
</tbody>
</table>

| 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 | Tab: 35 | Specialty Developing Recommendation: | First | Identified: April 2016 | 2020 | Medicare | Utilization: | 2022 Work RVU: | 0.60 |
| RUC Recommendation: | Remove from screen | Referral to CPT | Result: Remove from screen | 2022 NF PE RVU: | NA | 2022 Fac PE RVU: 0.30 | 0.30 |

| 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: XXX | Issue: Negative Pressure Wound Therapy | Screen: CMS Request - Final Rule for 2013 | Complete? | Yes |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------|-------------------------------------------------|----------|
| Most Recent | Tab: 17 | Specialty Developing Recommendation: | First | Identified: November 2012 | 2020 | Medicare | Utilization: | 2022 Work RVU: | 0.70 |
| RUC Recommendation: | RUC recommended to survey but no specialty society interest followed. CMS deleted. | Referral to CPT | Result: Deleted from CPT | 2022 NF PE RVU: | 0.40 | 2022 Fac PE RVU: | 0.30 |
### Status Report: CMS Requests and Relativity Assessment Issues

<table>
<thead>
<tr>
<th>Status</th>
<th>CMS Requests and Relativity Assessment Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0457</strong></td>
<td>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</td>
</tr>
</tbody>
</table>

#### Global: Negative Pressure Wound Therapy

<table>
<thead>
<tr>
<th>Issue:</th>
<th>Issue: Negative Pressure Wound Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen:</td>
<td>CMS Request - Final Rule for 2013</td>
</tr>
<tr>
<td>Complete?:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

<table>
<thead>
<tr>
<th>Most Recent RUC Meeting:</th>
<th>January 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tab:</td>
<td>17</td>
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<tr>
<td>Specialty Developing Recommendation:</td>
<td>Specialty Developing</td>
</tr>
<tr>
<td>First Identified:</td>
<td>November 2012</td>
</tr>
<tr>
<td>Medicare Utilization:</td>
<td>2020</td>
</tr>
<tr>
<td>Work RVU:</td>
<td>2022</td>
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<tr>
<td>NF PE RVU:</td>
<td>2022</td>
</tr>
<tr>
<td>Fac PE RVU:</td>
<td>2022</td>
</tr>
</tbody>
</table>

- **Referral to CPT:** Referred to CPT May 2013
- **Result:** Deleted from CPT

- **Referral to CPT Asst:** Published in CPT Asst:

#### 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

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<thead>
<tr>
<th>Issue:</th>
<th>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)</th>
</tr>
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<tbody>
<tr>
<td>Screen:</td>
<td>CMS-Other - Utilization over 20,000 Part2</td>
</tr>
<tr>
<td>Complete?:</td>
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</table>

#### RUC Recommendation: Maintain

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<tr>
<th>Most Recent RUC Meeting:</th>
<th>January 2021</th>
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<tbody>
<tr>
<td>Tab:</td>
<td>29</td>
</tr>
<tr>
<td>Specialty Developing Recommendation:</td>
<td>Specialty Developing</td>
</tr>
<tr>
<td>First Identified:</td>
<td>October 2020</td>
</tr>
<tr>
<td>Medicare Utilization:</td>
<td>2020</td>
</tr>
<tr>
<td>Work RVU:</td>
<td>2022</td>
</tr>
<tr>
<td>NF PE RVU:</td>
<td>2022</td>
</tr>
<tr>
<td>Fac PE RVU:</td>
<td>2022</td>
</tr>
</tbody>
</table>

- **Referral to CPT:** Referred to CPT
- **Result:** Remove from screen

- **Referral 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

<table>
<thead>
<tr>
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<th>Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)</th>
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<tbody>
<tr>
<td>Screen:</td>
<td>CMS-Other - Utilization over 20,000 Part2</td>
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<tr>
<td>Complete?:</td>
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#### RUC Recommendation: Request CMS Delete

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<tr>
<td>Tab:</td>
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<tr>
<td>Specialty Developing Recommendation:</td>
<td>Specialty Developing</td>
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<tr>
<td>First Identified:</td>
<td>October 2020</td>
</tr>
<tr>
<td>Medicare Utilization:</td>
<td>2020</td>
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<tr>
<td>Work RVU:</td>
<td>2022</td>
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<tr>
<td>NF PE RVU:</td>
<td>2022</td>
</tr>
<tr>
<td>Fac PE RVU:</td>
<td>2022</td>
</tr>
</tbody>
</table>

- **Referral to CPT:** Referred to CPT
- **Result:** Request CMS Delete

- **Referral to CPT Asst:** Published in CPT Asst:
<table>
<thead>
<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G6001</strong> Ultrasonic guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td><strong>Global:</strong> XXX  <strong>Issue:</strong>  <strong>Screen:</strong> CMS-Other - Utilization over 20,000 Part2  <strong>Complete?</strong> No</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2021  <strong>Tab:</strong> 29  <strong>Specialty Developing Recommendation:</strong> AADA, ASTRO</td>
</tr>
<tr>
<td><strong>First Identified:</strong> October 2020  <strong>2020 Medicare Utilization:</strong> 125,385  <strong>2022 Work RVU:</strong> 0.58  <strong>2022 NF PE RVU:</strong> 4.69</td>
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<tr>
<td><strong>RUC Recommendation:</strong> Refer to CPT</td>
</tr>
<tr>
<td><strong>Referred to CPT</strong>  <strong>February 2022</strong>  <strong>Result:</strong></td>
</tr>
<tr>
<td><strong>Referred to CPT Asst</strong>  <strong>Published in CPT Asst:</strong></td>
</tr>
</tbody>
</table>

| **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  **2020 Medicare Utilization:** 1,083,968  **2022 Work RVU:** 0.39  **2022 NF PE RVU:** 1.76 |
| **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  **2020 Medicare Utilization:** 309,318  **2022 Work RVU:** 0.00  **2022 NF PE RVU:** 7.10 |
| **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

<table>
<thead>
<tr>
<th>G6013</th>
<th>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part2</th>
<th>Complete?</th>
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<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>RUC Recommendation:</td>
<td>Review action plan</td>
<td>Referred to CPT</td>
<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>G6014</th>
<th>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater</th>
<th>Global: XXX</th>
<th>Issue: RAW</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part1</th>
<th>Complete? Yes</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>RUC Recommendation:</td>
<td>Remove from screen</td>
<td>Referred to CPT</td>
<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>G6015</th>
<th>Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mic, per treatment session</th>
<th>Global: XXX</th>
<th>Issue:</th>
<th>Screen: CMS-Other - Utilization over 20,000 Part2</th>
<th>Complete? No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>RUC Recommendation:</td>
<td>Review action plan</td>
<td>Referred to CPT</td>
<td>Referred to CPT Asst</td>
<td>Published in CPT Asst:</td>
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Tuesday, February 1, 2022
<table>
<thead>
<tr>
<th>Status Report: CMS Requests and Relativity Assessment Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G6017</strong> Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3d positional tracking, gating, 3d surface tracking), each fraction of treatment</td>
</tr>
<tr>
<td><strong>Global:</strong> YYY <strong>Issue:</strong> Global: YYY <strong>Screen:</strong> CMS-Other - Utilization over 20,000 Part2 <strong>Complete?</strong> No</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2021 <strong>Tab:</strong> 29 <strong>Specialty Developing Recommendation:</strong> Review action plan</td>
</tr>
<tr>
<td><strong>First Identified:</strong> October 2020 <strong>2020 Medicare Utilization:</strong> 81,098</td>
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<tr>
<td><strong>2022 Work RVU:</strong> 0.00 <strong>2022 NF PE RVU:</strong> 0.00 <strong>2022 Fac PE RVU:</strong> 0.00</td>
</tr>
<tr>
<td><strong>Result:</strong> No recommendation on physician work, time or PE for this code. CMS estimates of utilization for code G6017 should be more conservative.</td>
</tr>
<tr>
<td><strong>Referred to CPT</strong></td>
</tr>
<tr>
<td><strong>Referred to CPT Asst:</strong></td>
</tr>
<tr>
<td><strong>GPCX1</strong> 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)</td>
</tr>
<tr>
<td><strong>Global:</strong> <strong>Issue:</strong> Visit Complexity E/M Add-On <strong>Screen:</strong> CMS Request - Final Rule for 2020 <strong>Complete?</strong> Yes</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> January 2020 <strong>Tab:</strong> 34 <strong>Specialty Developing Recommendation:</strong></td>
</tr>
<tr>
<td><strong>First Identified:</strong> November 2019 <strong>2020 Medicare Utilization:</strong></td>
</tr>
<tr>
<td><strong>2022 Work RVU:</strong> <strong>2022 NF PE RVU:</strong> <strong>2022 Fac PE RVU:</strong></td>
</tr>
<tr>
<td><strong>Result:</strong> N/A</td>
</tr>
<tr>
<td><strong>Referred to CPT</strong></td>
</tr>
<tr>
<td><strong>Referred to CPT Asst:</strong></td>
</tr>
<tr>
<td><strong>P3001</strong> Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician</td>
</tr>
<tr>
<td><strong>Global:</strong> XXX <strong>Issue:</strong> Cytopathology Cervical/Vaginal <strong>Screen:</strong> CMS-Other - Utilization over 30,000 <strong>Complete?</strong> Yes</td>
</tr>
<tr>
<td><strong>Most Recent RUC Meeting:</strong> April 2018 <strong>Tab:</strong> 26 <strong>Specialty Developing Recommendation:</strong> CAP</td>
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<tr>
<td><strong>First Identified:</strong> October 2017 <strong>2020 Medicare Utilization:</strong> 1,296</td>
</tr>
<tr>
<td><strong>2022 Work RVU:</strong> 0.26 <strong>2022 NF PE RVU:</strong> 0.38 <strong>2022 Fac PE RVU:</strong> 0.38</td>
</tr>
<tr>
<td><strong>Result:</strong> Maintain</td>
</tr>
<tr>
<td><strong>Referred to CPT</strong></td>
</tr>
<tr>
<td><strong>Referred to CPT Asst:</strong></td>
</tr>
</tbody>
</table>
### Status Report: CMS Requests and Relativity Assessment Issues

**Q0091** Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

<table>
<thead>
<tr>
<th>Global: XXX</th>
<th>Issue: RAW</th>
<th>Screen: CMS-Other - Utilization over 30,000-Part2</th>
<th>Complete?</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Most Recent RUC Meeting:** January 2019

**Tab:** 37

**Specialty Developing Recommendation:** No Specialty Society Interest

**First Identified:** October 2018

**2020 Medicare Utilization:** 410,577

**2022 Work RVU:** 0.37

**2022 NF PE RVU:** 0.86

**2022 Fac PE RVU:** 0.14

**RUC Recommendation:** RUC recommended to survey but no specialty society interest followed.

**Referred to CPT:**

**Result:** Maintain

**Published in CPT Asst:**
**RUC Referrals to CPT Editorial Panel - Outstanding Issues**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Screen</th>
<th>RUC Meeting</th>
<th>Specialty Society</th>
<th>CPT Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>37220</td>
<td>Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37221</td>
<td>Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37222</td>
<td>Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37223</td>
<td>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)</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
</tbody>
</table>

**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.
<table>
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<tr>
<th>RUC Code</th>
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<th>Specialty Society</th>
<th>CPT Meeting</th>
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</thead>
<tbody>
<tr>
<td>37224</td>
<td>Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37225</td>
<td>Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>High Volume Growth1 / PE Screen - High Cost Supplies</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37226</td>
<td>Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
<tr>
<td>37227</td>
<td>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</td>
<td>High Volume Growth1 / PE Screen - High Cost Supplies</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
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**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.
### RUC Referrals to CPT Editorial Panel - Outstanding Issues

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<tbody>
<tr>
<td>37228</td>
<td>Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
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**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.

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<th>CPT Meeting</th>
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<tbody>
<tr>
<td>37229</td>
<td>Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
</tr>
</tbody>
</table>

**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.

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<th>RUC Code</th>
<th>Description</th>
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<th>RUC Meeting</th>
<th>Specialty Society</th>
<th>CPT Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>37230</td>
<td>Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
<td>SVS, ACS, SIR, ACR, ACC</td>
<td>September 2021</td>
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</tbody>
</table>

**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.

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<td>37231</td>
<td>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</td>
<td>High Volume Growth1</td>
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## RUC Referrals to CPT Editorial Panel - Outstanding Issues

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<tr>
<td>37232</td>
<td>Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transmural angioplasty (List separately in addition to code for primary procedure)</td>
<td>High Volume Growth1</td>
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<td>37233</td>
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<td>37234</td>
<td>Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transmural stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)</td>
<td>High Volume Growth1</td>
<td>January 2019</td>
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RUC Referrals to CPT Editorial Panel - Outstanding Issues

37235  
Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transmural stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)  
Screen  
High Volume Growth1  
RUC Meeting  
January 2019  
Specialty Society:  
SVS, ACS, SIR, ACR, ACC  
CPT Meeting  
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.

50080  
Percutaneous nephrostolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm  
Screen  
Site of Service Anomaly - 2019  
RUC Meeting  
January 2020  
Specialty Society:  
AUA  
CPT Meeting  
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.

50081  
Percutaneous nephrostolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm  
Screen  
Site of Service Anomaly - 2019  
RUC Meeting  
January 2020  
Specialty Society:  
AUA  
CPT Meeting  
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.

63030  
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foramintomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar  
Screen  
Pre-Time Analysis / Site of Service Anomaly - 2018  
RUC Meeting  
January 2021  
Specialty Society:  
AANS, AAOS, NASS  
CPT Meeting  
September 2021

Background:  
CPT code 63030 was identified via the site of service anomaly screen. 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.
**RUC Referrals to CPT Editorial Panel - Outstanding Issues**

**76998 Ultrasonic guidance, intraoperative**

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<tr>
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<th>Specialty Society:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CMS-Other - Utilization over 20,000 Part1</td>
<td>October 2019</td>
<td>STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS</td>
<td>September 2021</td>
</tr>
</tbody>
</table>

**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 issue to CPT Editorial Panel (May 2020) to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.

**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)**

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<tr>
<td>CMS Request - Final Rule for 2020</td>
<td>April 2021</td>
<td>AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS</td>
<td>September 2021, February 2021</td>
</tr>
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</table>

**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.

**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)**

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## RUC Referrals to CPT Editorial Panel - Outstanding Issues

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<tbody>
<tr>
<td>G0396</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes</td>
<td>CMS-Other - Utilization over 30,000</td>
<td>January 2018</td>
<td>AAFP, ASA, ASAM</td>
<td>Time Uncertain</td>
</tr>
</tbody>
</table>

**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.

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<tr>
<td>G6001</td>
<td>Ultrasonic guidance for placement of radiation therapy fields</td>
<td>CMS-Other - Utilization over 20,000 Part2</td>
<td>January 2021</td>
<td>AADA, ASTRO</td>
<td>September 2021</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>Screen:</th>
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<th>RUC Rec:</th>
<th>Specialty Society:</th>
<th>CPT Asst Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
<td>Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7</td>
<td>January 2021</td>
<td>Review action plan in 2 years after CPT article published. 6.05</td>
<td>AAPM, AANS/CNS, ASA, ISIS, NASS</td>
<td></td>
</tr>
<tr>
<td>75710</td>
<td>Angiography, extremity, unilateral, radiological supervision and interpretation</td>
<td>CMS High Expenditure Procedural Codes2</td>
<td>January 2021</td>
<td>Refer to CPT Assistant and review after 2 years of data after publication available. 1.75</td>
<td>ACR, ACC, RPA, SCAI, SIR, SVS</td>
<td>July 2021</td>
</tr>
<tr>
<td>G0407</td>
<td>Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth</td>
<td>CMS-Other - Utilization over 20,000 Part2</td>
<td>April 2021</td>
<td>Review action plan</td>
<td>AAN, ANA, APA (psychiatry)</td>
<td></td>
</tr>
</tbody>
</table>

### Background:
- 63685: 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 2019c. 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 review after 2 years of data are available after article is published.
- 75710: 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 since 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 2019c 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 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%.
- G0407: 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

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<td>G0408</td>
<td>Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth</td>
<td>CMS-Other - Utilization over 20,000 Part2</td>
<td>April 2021</td>
<td>Review action plan</td>
<td>AAN, ANA, APA (psychiatry)</td>
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**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 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.
| CPT Code | Pre-Service Evaluation | Pre-Service Positioning | Pre-Service Scrub Dress & Wait | Intra-Service | Immediate Post Service | 99211 | 99212 | 99213 | 99214 | 99215 | 99216 | 99231 | 99232 | 99233 | 99238 | 99239 | 99291 | 99292 | Total Time |
|----------|------------------------|------------------------|-------------------------------|--------------|-----------------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|----------|
| 22630    | 40                     | 20                     | 15                            | 150          | 30                    | 2    | 1    | 1    | 1    | 2    | 1    | 1    | 1    | 1    | 1    | 1    | 479    |
| 22632    | 60                     |                        |                               |              |                       |      |      |      |      |      |      |      |      |      |      |      |      | 60     |
| 22633    | 40                     | 20                     | 15                            | 180          | 30                    | 2    | 1    | 1    | 2    | 1    | 1    | 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    |      |      |      |      |      |      |      |      |      |      | 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      |
### 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 |
|----------|------------------------|-------------------------|--------------------------------|---------------|------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|----------|
| 0X41A    |                        |                         |                                |               |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 7 |
| 0X42A    |                        |                         |                                |               |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 7 |
| 157X1    | 40                     | 3                       | 15                              | 90             | 25                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 213 |
| 42XX     | 18                     | 1                       | 6                               | 15             | 10                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 50 |
| 43X21    | 18                     | 3                       | 5                               | 30             | 20                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 76 |
| 43X22    | 18                     | 3                       | 5                               | 30             | 15                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 71 |
| 49X01    | 25                     | 3                       | 15                              | 45             | 20                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 108 |
| 49X02    | 35                     | 3                       | 15                              | 60             | 30                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 143 |
| 49X03    | 30                     | 10                      | 15                              | 90             | 30                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 175 |
| 49X04    | 35                     | 15                      | 15                              | 120            | 40                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 225 |
| 49X05    | 40                     | 15                      | 15                              | 120            | 40                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 230 |
| 49X06    | 40                     | 15                      | 15                              | 160            | 25                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 310 |
| 49X07    | 30                     | 10                      | 15                              | 60             | 20                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 135 |
| 49X08    | 35                     | 10                      | 15                              | 75             | 30                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 165 |
| 49X09    | 35                     | 10                      | 15                              | 100            | 30                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 190 |
| 49X10    | 40                     | 15                      | 15                              | 140            | 25                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 275 |
| 49X11    | 40                     | 15                      | 15                              | 150            | 28                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 288 |
| 49X12    | 40                     | 15                      | 15                              | 180            | 30                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 335 |
| 49X13    | 40                     | 15                      | 15                              | 120            | 25                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 235 |
| 49X14    | 40                     | 15                      | 15                              | 150            | 25                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 285 |
| 49X15    | 45                     |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 45  |
| 630X1    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 40  |
| 630XX    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 45  |
| 69X50    | 32                     | 3                       | 10                              | 60             | 15                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 185 |
| 69X51    | 33                     | 3                       | 10                              | 60             | 15                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 186 |
| 69X52    | 32                     | 3                       | 10                              | 30             | 15                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 148 |
| 69X53    | 33                     | 3                       | 10                              | 45             | 15                     |       |       |       |       |       |       |       |       |       |       |       |       |          | 164 |
| 96X70    | 2                      |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 15  |
| 96X71    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 3   |
| G0008    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 7   |
| G0009    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 7   |
| G0010    |                        |                          |                                |                |                        |       |       |       |       |       |       |       |       |       |       |       |       |          | 7   |
## Detailed Description of Pre-Service Time Packages (Minutes)

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<th>CATEGORY SUBTOTALS</th>
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<th>NON-FAC</th>
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<tr>
<td>Total Pre-Service Time</td>
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### DETAILS

<table>
<thead>
<tr>
<th>A</th>
<th>History and Exam (Performance and review of appropriate Pre-Tests)</th>
<th>5</th>
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<th>10</th>
<th>15</th>
<th>4</th>
<th>9</th>
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<tbody>
<tr>
<td>A</td>
<td>Prepare for Procedure (Check labs, plan, assess risks, review procedure)</td>
<td>2</td>
<td>2</td>
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<td>A</td>
<td>Communicate with patient and/or family (Discuss procedure/ obtain consent)</td>
<td>3</td>
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<td>A</td>
<td>Communicate with other professionals</td>
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<td>A</td>
<td>Check/set-up room, supplies and equipment</td>
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<td>A</td>
<td>Check/ prepare patient readiness (Gown, drape, prep, mark)</td>
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<tr>
<td>A</td>
<td>Prepare/ review/ confirm procedure</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>B</td>
<td>Perform/ supervise patient positioning</td>
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<td>C</td>
<td>Administer local/topical anesthesia</td>
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<td>C</td>
<td>Observe (wait anesthesia care)</td>
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<td>C</td>
<td>Dress and scrub for procedure</td>
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</table>

**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

<table>
<thead>
<tr>
<th>SS1</th>
<th>Anterior Neck Surgery (Supine) (eg ACDF)</th>
<th>15 Minutes</th>
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</thead>
<tbody>
<tr>
<td>SS2</td>
<td>Posterior Neck Surgery (Prone) (eg laminectomy)</td>
<td>25 Minutes</td>
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<tr>
<td>SS3</td>
<td>Posterior Thoracic/Lumbar (Prone) (eg laminectomy)</td>
<td>15 Minutes</td>
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<tr>
<td>SS4</td>
<td>Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)</td>
<td>25 Minutes</td>
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<tr>
<td>SS5</td>
<td>Anterior Lumbar (Supine) (eg ALIF)</td>
<td>15 Minutes</td>
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### Additional Positioning Times for Spinal Injection Procedures

<table>
<thead>
<tr>
<th>SI1</th>
<th>Anterior Neck Injection (Supine) (eg discogram)</th>
<th>7 Minutes</th>
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</thead>
<tbody>
<tr>
<td>SI2</td>
<td>Posterior Neck Injection (Prone) (eg facet)</td>
<td>5 Minutes</td>
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<tr>
<td>SI3</td>
<td>Posterior Thoracic/Lumbar (Prone) (eg epidural)</td>
<td>5 Minutes</td>
</tr>
<tr>
<td>SI4</td>
<td>Lateral Thoracic/Lumbar (Lateral) (eg discogram)</td>
<td>7 Minutes</td>
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</table>

### 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)

<table>
<thead>
<tr>
<th>Details</th>
<th>7A Local Anesthesia/ Straightforward Procedure</th>
<th>7B Local Anesthesia/ Complex Procedure</th>
<th>8A IV Sedation/ Straightforward Procedure</th>
<th>8B IV Sedation/ Complex Procedure</th>
<th>9A General Anesthesia or Complex Regional Block/ Straightforward Procedure</th>
<th>9B General Anesthesia or Complex Regional Block/Complex Procedure</th>
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<tbody>
<tr>
<td>Total Post-Service Time</td>
<td>18</td>
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<td>Monitor patient recovery/stabilization</td>
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Advisors may request additional time for circumstances that require additional work beyond the type of work described

1 This represents a simple dressing
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93655
93656
93613
93662
93657
93613
93621
93662
43235
43999
43999
43247
49560
49654
49570
49585
49652
49590
49560
49654
49570
49585
49652
49590
49560
49654
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49652
49590
49590
49561
49655
49572
49587
49653
49590
49561

Deleted

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D

Source 2019
Utilization
5,654
1,875
38,096
14,338
101,838
101,838
128,927
128,927
301
301
31,821
80,773
29,892
7,750
31,147
53,327
80,773
63,470
21,159
80,773
29,892
63,470
323,621
7,587
7,587
28,637
22,089
7,253
616
18,847
9,327
714
22,089
7,253
616
18,847
9,327
714
22,089
7,253
18,847
9,327
714
714
12,726
4,804
451
7,947
5,848
714
12,726

New/ Revised Code
22630
22632
22633
22634
630XX
63047
630X1
63048
42XXX
31599
93653
Util Savings (Bundled into 93653)
Util Savings (Bundled into 93653)
93654
93655
93656
Util Savings (Bundled into 93656)
Util Savings (Bundled into 93656)
93657
93613
93621
93662
43235
43X21
43999
43X22
49X01
49X01
49X01
49X01
49X01
49X01
49X03
49X03
49X03
49X03
49X03
49X03
49X05
49X05
49X05
49X05
49X05
49X02
49X02
49X02
49X02
49X02
49X02
49X04
49X04

New/Revised
Code Utilization Percent
(reference 2019)
5,654
1,875
38,096
14,338
11,000
90,838
4,000
124,927
100
201
31,821
27,172
23,134
7,750
31,147
53,327
49,327
48,277
21,159
4,274
6,758
15,193
323,621
2,523
5,064
2,523
14,358
2,901
610
17,905
7,462
393
6,627
3,627
6
754
1,399
250
884
653
188
466
36
8,272
3,123
446
6,755
4,971
36
3,818

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1.000
1.000
1.000
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0.892
0.031
0.969
0.332
0.668
1.000
0.336
0.774
1.000
1.000
1.000
0.611
0.761
1.000
0.053
0.226
0.239
1.000
0.333
0.667
0.088
0.650
0.400
0.990
0.950
0.800
0.550
0.300
0.500
0.010
0.040
0.150
0.350
0.040
0.090
0.010
0.050
0.000
0.050
0.650
0.650
0.990
0.850
0.850
0.050
0.300

RUC
Source
Rec
RVU
RVU

RUC Tab

New/ Revised
Total RVUs

Total Source
RVUs

22.09
5.22
27.75
8.16
7.69
7.69
3.47
3.47
0.00
0.00
14.75
5.23
2.10
19.75
7.50
19.77
5.23
2.80
7.50
5.23
2.10
1.44
2.09
0.00
0.00
3.11
11.92
13.76
6.05
6.59
11.92
8.90
11.92
13.76
6.05
6.59
11.92
8.90
11.92
13.76
6.59
11.92
8.90
8.90
15.38
16.84
7.87
7.08
14.94
8.90
15.38

04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
04 Arthrodesis Decompression
05 Drug Induced Sleep Endoscopy
05 Drug Induced Sleep Endoscopy
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
07 Cardiac Ablation
08 Endoscopic Bariatric Device Procedures
08 Endoscopic Bariatric Device Procedures
08 Endoscopic Bariatric Device Procedures
08 Endoscopic Bariatric Device Procedures
09 Anterior Abdominal Hernia Repair
09 Anterior Abdominal Hernia Repair
09 Anterior Abdominal Hernia Repair
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09 Anterior Abdominal Hernia Repair

124,897
9,788
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114,130
62,700
698,090
20,000
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195
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477,315
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0
140,275
218,029
906,559
0
0
148,113
22,353
11,827
38,438
676,368
7,847
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7,064
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18,191
3,824
112,262
46,784
2,462
71,568
39,166
67
8,142
15,110
2,699
13,147
9,713
2,804
6,939
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74,447
28,103
4,018
60,795
44,737
500
53,449

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84,535
698,090
13,880
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469,360
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135,176
158,693
22,353
14,192
21,878
676,368
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0
7,847
171,146
39,921
3,690
117,992
88,942
3,495
78,990
49,901
37
4,968
16,677
2,224
10,532
8,982
1,242
5,559
0
318
127,222
52,585
3,514
47,825
74,264
318
58,718

22.09
5.22
26.80
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5.70
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18.10
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17.00
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7.00
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2.09
3.11
0.00
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6.27
6.27
6.27
6.27
6.27
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10.80
10.80
10.80
10.80
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14.88
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9.00
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14.00
14.00


Source 2019
Utilization

CPT Source

Deleted

49655
49572
49587
49653
49561
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49656
49561
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49657
49568

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4,804
451
7,947
5,848
12,726
4,804
7,947
5,848
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1,697
5,211
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1,503
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1,503
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22,089
7,253
5,211
1,697
12,726
4,804
3,748
1,503
27,767

49568

D

27,767 Util Savings (bundled into X01-X12)

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49999
49659
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49999
49580
49582

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D

980
1,327
980
1,327
980
1,327
1,327
1,327
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New/ Revised Code
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49X04
49X04
49X04
49X06
49X06
49X06
49X06
49X07
49X07
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49X13
49X13
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49X14
49X14
49X14
49X14
157X1
49X13
49X13
49X14
49X14
+49X15
+49X15
157X1
49999
Savings
Savings

New/Revised
Code Utilization Percent
(reference 2019)
1,441
5
1,113
819
509
192
79
58
1,303
339
3,387
1,188
469
153
750
301
2,624
1,052
337
135
221
73
52
17
127
48
37
15
278

RUC
Source
Rec
RVU
RVU

RUC Tab

New/ Revised
Total RVUs

Total Source
RVUs

16.84
7.87
7.08
14.94
15.38
16.84
7.08
14.94
12.37
15.08
12.37
15.08
12.37
15.08
15.53
22.11
15.53
22.11
15.53
22.11
11.92
13.76
12.37
15.08
15.38
16.84
15.53
22.11
4.88

14.00
14.00
14.00
14.00
20.00
20.00
20.00
20.00
7.75
7.75
12.00
12.00
16.97
16.97
10.79
10.79
16.50
16.50
24.00
24.00
14.24
14.24
14.24
14.24
18.00
18.00
18.00
18.00
8.00

09 Anterior Abdominal Hernia Repair
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09 Anterior Abdominal Hernia Repair

20,177
63
15,576
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43,289
17,360
8,096
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242
2,291
865
675
271
2,221

24,270
35
7,877
12,232
7,829
3,236
563
874
16,115
5,118
41,899
17,914
5,801
2,303
11,641
6,646
40,745
23,262
5,239
2,991
2,633
998
645
256
1,957
809
582
332
1,355

4.88

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09 Anterior Abdominal Hernia Repair

0

134,148

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0.150
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0.350
0.100
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1.000

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0.00
0.00
0.00
0.00
0.00
0.00
0.00
4.47
7.13

14.24
14.24
18.00
18.00
5.00
5.00
8.00
0.00
0.00
0.00

09 Anterior Abdominal Hernia Repair
09 Anterior Abdominal Hernia Repair
09 Anterior Abdominal Hernia Repair
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09 Anterior Abdominal Hernia Repair
09 Anterior Abdominal Hernia Repair

2,093
2,834
6,174
8,360
490
500
106
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0
0

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0
0
0
0
0
0
0
0
0

0.300
0.010
0.140
0.140
0.040
0.040
0.010
0.010
0.250
0.200
0.650
0.700
0.090
0.090
0.200
0.200
0.700
0.700
0.090
0.090
0.010
0.010
0.010
0.010
0.010
0.010
0.010
0.010
0.010

27,489 0.990
147
199
343
464
98
100
13
550
-

99212 visits bundled into
surgical global for deleted D
codes 49560-49657

-

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 D
codes 49560-49657

-

99213

102,781 1.000

0.00

1.30

09 Anterior Abdominal Hernia Repair

133,615

0


CPT Source

Deleted

Source 2019
Utilization

New/ Revised Code

New/Revised
Code Utilization Percent
(reference 2019)

RUC
Source
Rec
RVU
RVU

RUC Tab

New/ Revised
Total RVUs

Total Source
RVUs

99231 visits bundled into
surgical global for deleted D
codes 49561-49657

-

99231

25,336 1.000

0.00

0.76

09 Anterior Abdominal Hernia Repair

19,255

0

99232 visits bundled into
surgical global for deleted D
codes 49561-49657

-

99232

43,764 1.000

0.00

1.39

09 Anterior Abdominal Hernia Repair

60,832

0

32,858 92065
32,858 920XX

14,786 0.450
18,072 0.550
1.000
1.000
67,730 1.000
352,496 1.000
2,744,710 1.000
5,415,650 1.000
11,514,274 1.000
336,776 1.000
1,054,727 1.000
1,389,990 1.000
2,372,760 1.000
11,302,104 1.000
10,009,767 1.000
1,671,664 1.000
10,013 0.100
85,107 0.850
5,006 0.050
4,248 1.000
1,382 1.000
45,645 1.000
6,795 1.000
2,884 1.000
15,803 1.000
312,130 1.000
301 1.000
58 1.000
282,357 1.000
22,524 1.000
3 1.000
1 1.000
15,066,497 1.000
3,142,650 1.000
71,927 1.000
32,615 1.000
7,182 1.000
- 1.000
- 1.000
1 1.000
- 1.000

0.37
0.37

0.71
0.00

10 Orthoptic Training
10 Orthoptic Training

0.00

0.43

11 Caregiver Behavior Management Training

10,498
0
0

5,471
6,687
0

0.00

0.12

11 Caregiver Behavior Management Training

0

0

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1.60
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4.00
1.64
2.35
3.06
0.76
1.16
1.55
2.35
1.71
1.71
1.71
0.00
0.00
3.80
7.03
2.34
17.48
19.60
0.17
0.15
0.17
0.15
0.17
0.15
0.17
0.17
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0.00
0.00
0.00

0.25
0.93
1.60
2.60
4.00
1.50
2.50
3.50
0.70
1.30
1.92
2.80
1.30
1.92
2.80
0.00
0.00
3.50
7.03
2.34
17.13
19.60
0.24
0.18
0.17
0.15
0.17
0.15
0.17
0.17
0.17
0.14
0.40
0.00
0.00
0.00
0.00

12 Emergency Department Services
12 Emergency Department Services
12 Emergency Department Services
12 Emergency Department Services
12 Emergency Department Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
13 Nursing Facility Services
15 Prolonged Services - Clinical Staff Services (PE Only)
15 Prolonged Services - Clinical Staff Services (PE Only)
16 Cognitive Assessment and Care Plan Services
17 Insertion of Spinal Stability Distractive Device
17 Insertion of Spinal Stability Distractive Device
18 Knee Arthroplasty
18 Knee Arthroplasty
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
19 Immunization Administration
20 Dark Adaptation Eye Exam
21 Anterior Segment Imaging
Category III Sundown for CPT 2022
Category III Sundown for CPT 2022
Category III Sundown for CPT 2022
Category III Sundown for CPT 2022

16,933
327,821
4,391,536
14,080,690
46,057,096
505,164
2,636,818
4,864,965
1,660,932
14,692,735
19,218,753
4,680,659
13,017
163,405
14,017
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6,749
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48,001
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2,561,304
534,251
12,228
4,566
2,873
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32,510
327,821
4,391,536
14,838,881
46,057,096
552,313
2,478,608
4,253,369
1,803,298
13,110,441
15,515,139
3,928,410
17,122
145,533
8,560
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0
173,451
47,769
6,749
276,236
6,117,748
51
9
48,001
3,379
1
0
2,561,304
534,251
12,228
7,828
5,817
0
0
0
0

92065
92065
New service not currently
reported
New service not currently
reported
99281
99282
99283
99284
99285
99304
99305
99306
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# New Technology/New Services List

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<th>CPT Code</th>
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<th>RUC Meeting</th>
<th>Issue</th>
<th>CPT Year</th>
<th>Date to Re-Review</th>
<th>RUC Rec</th>
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<tr>
<td>0001A</td>
<td>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</td>
<td>Dec 2020</td>
<td>Pfizer-SARS-CoV-2-IA</td>
<td>CPT 2020</td>
<td>January 2025</td>
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<td>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</td>
<td>Dec 2020</td>
<td>Pfizer-SARS-CoV-2-IA</td>
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<td>Dec 2020</td>
<td>Moderna-SARS-CoV-2-IA</td>
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<td>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</td>
<td>Jan 2021</td>
<td>AstraZeneca-SARS-CoV-2-IA</td>
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<td>Jan 2021</td>
<td>AstraZeneca-SARS-CoV-2-IA</td>
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<td>January 2025</td>
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<td>0031A</td>
<td>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</td>
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<td>Janssen-SARS-CoV-2-IA</td>
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<td>0041A</td>
<td>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</td>
<td>Apr 2021</td>
<td>Novavax-SARS-CoV-2-IA</td>
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<td>Novavax-SARS-CoV-2-IA</td>
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<td>CPT 2021</td>
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<td>Fine needle aspiration biopsy, including MR guidance; first lesion</td>
<td>Jan 2018</td>
<td>Fine Needle Aspiration</td>
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<td>04</td>
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<td>14302</td>
<td>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)</td>
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<td>Adjacent Tissue Transfer</td>
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<td>15271</td>
<td>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</td>
<td>Apr 2011</td>
<td>Chronic Wound Dermal Substitute</td>
<td>4</td>
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<td>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)</td>
<td>Apr 2011</td>
<td>Chronic Wound Dermal Substitute</td>
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<td>CPT 2012 October 2015</td>
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<td>15273</td>
<td>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</td>
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<td>Chronic Wound Dermal Substitute</td>
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<td>CPT 2012 October 2015</td>
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<td>CPT 2012 October 2015</td>
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<td>Apr 2011</td>
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<td>Apr 2011</td>
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<td>Tissue Grafting Procedures</td>
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<td>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)</td>
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<td>Tissue Grafting Procedures</td>
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<td>Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue</td>
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<td>Destruction of cutaneous vascular proliferative lesions (eg, laser technique);</td>
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<td>Destruction of Skin</td>
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<td>Destruction of cutaneous vascular proliferative lesions (eg, laser technique);</td>
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<td>Fibroadenoma Cryoablation</td>
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<td>Preparation of tumor cavity, with placement of a radiation therapy applicator</td>
<td>Oct 2016</td>
<td>Intraoperative Radiation</td>
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<td>CPT 2018</td>
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<td>Needle insertion(s) without injection(s); 1 or 2 muscle(s)</td>
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<td>January 2024</td>
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<td>Jan 2019</td>
<td>Trigger Point Dry Needling</td>
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<td>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)</td>
<td>Apr 2008</td>
<td>Computer Dependent External Fixation</td>
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<td>CPT 2009</td>
<td>September 2012</td>
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<td>20697</td>
<td>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</td>
<td>Apr 2008</td>
<td>Computer Dependent External Fixation</td>
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<td>Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)</td>
<td>Oct 2018</td>
<td>Drug Delivery Implant Procedures</td>
<td>05</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<td>20701</td>
<td>Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)</td>
<td>Oct 2018</td>
<td>Drug Delivery Implant Procedures</td>
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<td>January 2024</td>
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<td>20702</td>
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<td>Oct 2018</td>
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<td>CPT 2020</td>
<td>January 2024</td>
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<td>Drug Delivery Implant Procedures</td>
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<td>CPT 2020</td>
<td>January 2024</td>
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<td>20704</td>
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<td>CPT 2020</td>
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<tr>
<td>20705</td>
<td>Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)</td>
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<td>Drug Delivery Implant Procedures</td>
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<td>CPT 2020</td>
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<td>20983</td>
<td>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</td>
<td>Apr 2014</td>
<td>Cryoablation Treatment of the Bone Tumors</td>
<td>04</td>
<td>CPT 2015</td>
<td>October 2018</td>
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<tr>
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<th>Issue</th>
<th>CPT Year</th>
<th>Date to Review</th>
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<td>21011</td>
<td>Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
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<td>October 2017</td>
<td>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.</td>
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<td>21012</td>
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<td>21013</td>
<td>Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm</td>
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<td>21552</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<td>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.</td>
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<td>21558</td>
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<td>Apr 2014</td>
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<td>05</td>
<td>October 2018</td>
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<td>visualization when performed, unilateral; 1-3 ribs</td>
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<td>21812</td>
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<td>visualization when performed, unilateral; 4-6 ribs</td>
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<td>visualization when performed, unilateral; 7 or more ribs</td>
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<td>21931</td>
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<tr>
<td>21932</td>
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<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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- 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.
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<td>21935</td>
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<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</td>
<td>Apr 2006</td>
<td>Percutaneous Intradiscal Annuloplast</td>
<td>13</td>
<td>September 2010</td>
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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.

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<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)</td>
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<td>22856</td>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophysectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical</td>
<td>Apr 2008</td>
<td>Cervical Arthroplasty</td>
<td>7</td>
<td>September 2012</td>
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<td>22857</td>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar</td>
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<td>Lumbar Arthroplasty</td>
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<td>22862</td>
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<td>22864</td>
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<td>22865</td>
<td>Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar</td>
<td>Feb 2006</td>
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<td>September 2010</td>
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<td>22867</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level</td>
<td>Jan 2016</td>
<td>Insertion of Spinal Stability Distractive Device</td>
<td>05</td>
<td>Oct 2020</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>22868</td>
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<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
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<td>22870</td>
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<td>22902</td>
<td>Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm</td>
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<tr>
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<td>23071</td>
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<td>Feb 2009</td>
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<td>October 2017</td>
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| 23076    | Excision, tumor, soft tissue of shoulder area, subfascial (e.g., 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.
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<tr>
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<td>Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>23078</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater</td>
<td>Feb 2009</td>
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<tr>
<td>23200</td>
<td>Radical resection of tumor; clavicle</td>
<td>Feb 2009</td>
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<tr>
<td>23210</td>
<td>Radical resection of tumor; scapula</td>
<td>Feb 2009</td>
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<td>23220</td>
<td>Radical resection of tumor, proximal humerus</td>
<td>Feb 2009</td>
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<tr>
<td>24073</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater</td>
<td>Feb 2009</td>
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<td>24075</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>24076</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
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<td>24077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
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<td>24079</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater</td>
<td>Feb 2009</td>
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<td>24150</td>
<td>Radical resection of tumor, shaft or distal humerus</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>24152</td>
<td>Radical resection of tumor, radial head or neck</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2015</td>
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<td>25071</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>25073</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>25075</td>
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<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<td>Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>25077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>25078</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater</td>
<td>Feb 2009</td>
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<td>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.</td>
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<td>25170</td>
<td>Radical resection of tumor, radius or ulna</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2015</td>
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<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>26111</td>
<td>Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>26113</td>
<td>Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<td>26115</td>
<td>Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>26116</td>
<td>Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>26117</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>26118</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>26250</td>
<td>Radical resection of tumor, metacarpal</td>
<td>Feb 2009</td>
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<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>26260</td>
<td>Radical resection of tumor, proximal or middle phalanx of finger</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>26262</td>
<td>Radical resection of tumor, distal phalanx of finger</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>27043</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<tr>
<td>27045</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<td>27047</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>27048</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>27049</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>27059</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>27075</td>
<td>Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>27076</td>
<td>Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<td>✓</td>
</tr>
<tr>
<td>27077</td>
<td>Radical resection of tumor; innominate bone, total</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td></td>
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<tr>
<td>27078</td>
<td>Radical resection of tumor; ischial tuberosity and greater trochanter of femur</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td></td>
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<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
<td>Apr 2014</td>
<td>Sacroiliac Joint Fusion 08</td>
<td>CPT 2015</td>
<td>October 2018</td>
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<td>CPT Code</td>
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<tr>
<td>27280</td>
<td>Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed</td>
<td>Sep 2014</td>
<td>Sacroiliac Joint Fusion</td>
<td>06</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove form list, was only identified with 27279 and that code has been resurveyed April 2018.</td>
</tr>
<tr>
<td>27327</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<tr>
<td>27328</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<tr>
<td>27329</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td></td>
<td>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.</td>
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<tr>
<td>27337</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<tr>
<td>27339</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>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.</td>
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<td>Date to Re-Review</td>
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<tr>
<td>27364</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
<td>✔</td>
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<tr>
<td>27365</td>
<td>Radical resection of tumor, femur or knee</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔</td>
</tr>
<tr>
<td>27615</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<tr>
<td>27616</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>27618</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>27619</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>27632</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>27634</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>27645</td>
<td>Radical resection of tumor; tibia</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>27646</td>
<td>Radical resection of tumor; fibula</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
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<tr>
<td>27647</td>
<td>Radical resection of tumor; talus or calcaneus</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>28039</td>
<td>Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<td>28041</td>
<td>Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>28043</td>
<td>Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>28045</td>
<td>Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>✅</td>
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<tr>
<td>28046</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
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<tr>
<td>28047</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2017</td>
<td>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.</td>
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<tr>
<td>28171</td>
<td>Radical resection of tumor; tarsal (except talus or calcaneus)</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>28173</td>
<td>Radical resection of tumor; metatarsal</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>28175</td>
<td>Radical resection of tumor; phalanx of toe</td>
<td>Feb 2009</td>
<td>Excision of Soft Tissue and Bone Tumors</td>
<td>CPT 2010</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>29582</td>
<td>Code Deleted CPT 2018</td>
<td>Oct 2010</td>
<td>Multi-Layer Compression System-HCPAC</td>
<td>74</td>
<td>CPT 2012</td>
<td>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.</td>
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<td>CPT Code</td>
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<td>RUC Meeting</td>
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<td>CPT Year</td>
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<tr>
<td>29583</td>
<td>Code Deleted CPT 2018</td>
<td>Oct 2010</td>
<td>Multi-Layer Compression System-HCPAC</td>
<td>74 CPT 2012</td>
<td>October 2018</td>
<td>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.</td>
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<tr>
<td>29584</td>
<td>Application of multi-layer compression system; upper arm, forearm, hand, and fingers</td>
<td>Oct 2010</td>
<td>Multi-Layer Compression System-HCPAC</td>
<td>74 CPT 2012</td>
<td>January 2022</td>
<td>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).</td>
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<tr>
<td>29828</td>
<td>Arthroscopy, shoulder, surgical; biceps tenodesis</td>
<td>Apr 2007</td>
<td>Arthroscopic Biceps Tenodesis</td>
<td>17 CPT 2008</td>
<td>September 2011</td>
<td>Resurvey for January 2012</td>
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<tr>
<td>29914</td>
<td>Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)</td>
<td>Apr 2010</td>
<td>Hip Arthroscopy</td>
<td>5 CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
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<tr>
<td>29915</td>
<td>Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)</td>
<td>Apr 2010</td>
<td>Hip Arthroscopy</td>
<td>5 CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
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<td>CPT Code</td>
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<td>CPT Year</td>
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<tr>
<td>29916</td>
<td>Arthroscopy, hip, surgical; with labral repair</td>
<td>Apr 2010</td>
<td>Hip Arthroscopy</td>
<td>5</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa</td>
<td>Feb 2010</td>
<td>Nasal Sinus Endoscopy with Balloon Dilation</td>
<td>6</td>
<td>CPT 2011</td>
<td>October 2016</td>
<td>Surveying for January 2017 as part of bundling</td>
</tr>
<tr>
<td>31296</td>
<td>Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium</td>
<td>Feb 2010</td>
<td>Nasal Sinus Endoscopy with Balloon Dilation</td>
<td>6</td>
<td>CPT 2011</td>
<td>October 2016</td>
<td>Surveying for January 2017 as part of bundling</td>
</tr>
<tr>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium</td>
<td>Feb 2010</td>
<td>Nasal Sinus Endoscopy with Balloon Dilation</td>
<td>6</td>
<td>CPT 2011</td>
<td>October 2016</td>
<td>Surveying for January 2017 as part of bundling</td>
</tr>
<tr>
<td>31626</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple</td>
<td>Apr 2009</td>
<td>Fiducial Marker Placement</td>
<td>6</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>31627</td>
<td>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])</td>
<td>Feb 2009</td>
<td>Navigational Bronchoscopy</td>
<td>9</td>
<td>CPT 2010</td>
<td>October 2016</td>
<td>Review practice expense January 2014. Review data again in 3 years (Sept 2016).</td>
</tr>
<tr>
<td>31634</td>
<td>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</td>
<td>Feb 2010</td>
<td>Bronchoscopy with Balloon Occlusion</td>
<td>7</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>31647</td>
<td>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</td>
<td>Apr 2012</td>
<td>Bronchial Valve Procedures</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>RUC Meeting</td>
<td>Issue Tab</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
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<tr>
<td>31648</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe</td>
<td>Apr 2012</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
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<tr>
<td>31649</td>
<td>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)</td>
<td>Apr 2012</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>31651</td>
<td>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))</td>
<td>Apr 2012</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
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<tr>
<td>31652</td>
<td>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</td>
<td>Jan 2015</td>
<td>05</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td></td>
<td>✓</td>
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<tr>
<td>31653</td>
<td>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</td>
<td>Jan 2015</td>
<td>05</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td></td>
<td>✓</td>
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<tr>
<td>31654</td>
<td>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))</td>
<td>Jan 2015</td>
<td>05</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td></td>
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<tr>
<td>32553</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple</td>
<td>Apr 2009</td>
<td>Fiducial Marker Placement</td>
<td>6</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>32701</td>
<td>Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment</td>
<td>Jan 2012</td>
<td>Stereotactic Body Radiation</td>
<td>07</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>32994</td>
<td>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</td>
<td>Jan 2017</td>
<td>Cryoablation of Pulmonary Tumors</td>
<td>08</td>
<td>CPT 2018</td>
<td>January 2022</td>
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<tr>
<td>32998</td>
<td>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</td>
<td>Apr 2006</td>
<td>Percutaneous RF Pulmonary Tumor Ablation</td>
<td>15</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>33254</td>
<td>Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)</td>
<td>Apr 2006</td>
<td>Atrial Tissue Ablation and Reconstruction</td>
<td>17</td>
<td>CPT 2007</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>33255</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass</td>
<td>Apr 2006</td>
<td>Atrial Tissue Ablation and Reconstruction</td>
<td>17</td>
<td>CPT 2007</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>33256</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass</td>
<td>Apr 2006</td>
<td>Atrial Tissue Ablation and Reconstruction</td>
<td>17</td>
<td>CPT 2007</td>
<td>September 2011</td>
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<tr>
<td>33257</td>
<td>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)</td>
<td>Apr 2007</td>
<td>Add-on Maze Procedures</td>
<td>23</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
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<td>33258</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of</td>
<td>Apr 2007</td>
<td>Add-on Maze Procedures</td>
<td>23</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td></td>
<td>other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass</td>
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<tr>
<td>33259</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of</td>
<td>Apr 2007</td>
<td>Add-on Maze Procedures</td>
<td>23</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<td>other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass</td>
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<tr>
<td>33265</td>
<td>Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited</td>
<td>Apr 2006</td>
<td>Atrial Tissue Ablation and</td>
<td>17</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<td></td>
<td>(eg, modified maze procedure), without cardiopulmonary bypass</td>
<td></td>
<td>Reconstruction</td>
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<tr>
<td>33266</td>
<td>Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive</td>
<td>Apr 2006</td>
<td>Atrial Tissue Ablation and</td>
<td>17</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
<td>✓</td>
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<td></td>
<td>(eg, maze procedure), without cardiopulmonary bypass</td>
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<td>Reconstruction</td>
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<td>33270</td>
<td>Insertion or replacement of permanent subcutaneous implantable defibrillator system,</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable</td>
<td>09</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
<td>□</td>
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<tr>
<td></td>
<td>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</td>
<td></td>
<td>Defibrillator Procedures</td>
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<td>33271</td>
<td>Insertion of subcutaneous implantable defibrillator electrode</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable</td>
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<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
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<td>33272</td>
<td>Removal of subcutaneous implantable defibrillator electrode</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable</td>
<td>09</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
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<td>Defibrillator Procedures</td>
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<td>Date to Review</td>
<td>RUC Rec Complete</td>
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<tr>
<td>33273</td>
<td>Repositioning of previously implanted subcutaneous implantable defibrillator electrode</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable Defibrillator Procedures</td>
<td>09</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
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<tr>
<td>33274</td>
<td>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</td>
<td>Jan 2018</td>
<td>Leadless Pacemaker Procedures</td>
<td>07</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>33275</td>
<td>Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed</td>
<td>Jan 2018</td>
<td>Leadless Pacemaker Procedures</td>
<td>07</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>33285</td>
<td>Insertion, subcutaneous cardiac rhythm monitor, including programming</td>
<td>Apr 2017</td>
<td>Cardiac Event Recorder Procedures</td>
<td>07</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>33286</td>
<td>Removal, subcutaneous cardiac rhythm monitor</td>
<td>Apr 2017</td>
<td>Cardiac Event Recorder Procedures</td>
<td>07</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>33289</td>
<td>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</td>
<td>Jan 2018</td>
<td>Pulmonary Wireless Pressure Sensor Services</td>
<td>08</td>
<td>CPT 2019</td>
<td>January 2023</td>
<td></td>
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<tr>
<td>33340</td>
<td>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</td>
<td>Jan 2016</td>
<td>Closure Left Atrial Appendage with Endocardial Implant</td>
<td>10</td>
<td>CPT 2017</td>
<td>January 2023</td>
<td>Review in two years (January 2023); new FDA indication recently released, suggesting this service is still changing.</td>
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<tr>
<td>33361</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
<td>12</td>
<td>CPT 2013</td>
<td>January 2024</td>
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<tr>
<td>33362</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
<td>12</td>
<td>CPT 2013</td>
<td>January 2024</td>
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<td>33363</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
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<td>January 2024</td>
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<td>33364</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
<td>12</td>
<td>CPT 2013</td>
<td>January 2024</td>
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<tr>
<td>33365</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
<td>12</td>
<td>CPT 2013</td>
<td>January 2024</td>
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<tr>
<td>33366</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve Replacement</td>
<td>12</td>
<td>CPT 2013</td>
<td>January 2024</td>
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</table>

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.
<table>
<thead>
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<th>Issue</th>
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<tr>
<td>33367</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;</td>
<td>Apr 2012</td>
<td>Transcatheter Aortic Valve</td>
<td>12</td>
<td>CPT 2013</td>
<td>October 2016</td>
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<td></td>
<td>cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg,</td>
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<td>femoral vessels) (List separately in addition to code for primary procedure)</td>
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<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;</td>
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<td>CPT 2013</td>
<td>October 2016</td>
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<td></td>
<td>cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg,</td>
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<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;</td>
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<td>12</td>
<td>CPT 2013</td>
<td>October 2016</td>
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<td>33412</td>
<td>Replacement, aortic valve; with transventricular aortic annulus enlargement</td>
<td>Jan 2018</td>
<td></td>
<td>05</td>
<td>January 2023</td>
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<td>(Konno procedure)</td>
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<td>Aortoventriculoplasty with Pulmonary Autograft</td>
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<td>33413</td>
<td>Replacement, aortic valve; by translocation of autologous pulmonary valve with</td>
<td>Jan 2018</td>
<td></td>
<td>05</td>
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<td>Aortoventriculoplasty with Pulmonary Autograft</td>
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<td>33418</td>
<td>Transcatheter mitral valve repair, percutaneous approach, including transseptal</td>
<td>Apr 2014</td>
<td></td>
<td>10</td>
<td>January 2022</td>
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<td>Transcatheter Mitral Valve Repair</td>
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<td>Transcatheter mitral valve repair, percutaneous approach, including transseptal</td>
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<td>10</td>
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<td>puncture when performed; additional prosthesis(es) during same session (List</td>
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<td>Transcatheter Mitral Valve Repair</td>
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<td>separately in addition to code for primary procedure)</td>
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<tr>
<td>33440</td>
<td>Replacement, aortic valve; by translocation of autologous pulmonary valve and</td>
<td>Jan 2018</td>
<td></td>
<td>05</td>
<td>January 2023</td>
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<td>transventricular aortic annulus enlargement of the left ventricular outflow tract</td>
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<td>Aortoventriculoplasty with Pulmonary Autograft</td>
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<td>with valved conduit replacement of pulmonary valve (Ross-Konno procedure)</td>
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<td>33477</td>
<td>Transcatheter pulmonary valve implantation, percutaneous approach, including</td>
<td>Jan 2015</td>
<td></td>
<td>06</td>
<td>January 2023</td>
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<td>pre-stenting of the valve delivery site, when performed</td>
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<td>Transcatheter Pulmonary Valve Implantation</td>
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<td>33620</td>
<td>Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)</td>
<td>Feb 2010</td>
<td>Cardiac Hybrid Procedures</td>
<td>8</td>
<td>CPT 2011</td>
<td>September 2014</td>
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<td>33621</td>
<td>Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)</td>
<td>Feb 2010</td>
<td>Cardiac Hybrid Procedures</td>
<td>8</td>
<td>CPT 2011</td>
<td>September 2014</td>
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<td>33622</td>
<td>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)</td>
<td>Feb 2010</td>
<td>Cardiac Hybrid Procedures</td>
<td>8</td>
<td>CPT 2011</td>
<td>September 2014</td>
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<tr>
<td>33864</td>
<td>Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)</td>
<td>Apr 2007</td>
<td>Valve Sparing Aortic Annulus Reconstruction</td>
<td>24</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>✔️</td>
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<tr>
<td>33866</td>
<td>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)</td>
<td>Oct 2018</td>
<td>Aortic Graft Procedures</td>
<td>06</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<td>Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy</td>
<td>Jan 2017</td>
<td>Artificial Heart System Procedure</td>
<td>09</td>
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<td>33928</td>
<td>Removal and replacement of total replacement heart system (artificial heart)</td>
<td>Jan 2017</td>
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<td>09</td>
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<td>Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)</td>
<td>Jan 2017</td>
<td>Artificial Heart System Procedure</td>
<td>09</td>
<td>CPT 2018</td>
<td>January 2022</td>
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<td>33946</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11</td>
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<td>October 2018</td>
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<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial</td>
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<td>33948</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous</td>
<td>Apr 2014</td>
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<td>October 2018</td>
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<td>33949</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial</td>
<td>Apr 2014</td>
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<td>33951</td>
<td>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)</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11</td>
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<td>October 2018</td>
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<td>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)</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11 CPT 2015</td>
<td>October 2018</td>
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<td>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</td>
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<td>Apr 2014</td>
<td>ECMO-ECLS</td>
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<td>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</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11 CPT 2015</td>
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<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11 CPT 2015</td>
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<td>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)</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11 CPT 2015</td>
<td>October 2018</td>
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<td>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)</td>
<td>Apr 2014</td>
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<td>Apr 2014</td>
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<td>Apr 2014</td>
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<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>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</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
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<td>Apr 2014</td>
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<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
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<td>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)</td>
<td>Apr 2014</td>
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<td>11</td>
<td>October 2018</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>33988</td>
<td>Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS</td>
<td>Apr 2014</td>
<td>ECMO-ECLS</td>
<td>11</td>
<td>October 2018</td>
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<td>Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS</td>
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<td>Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only</td>
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<td>Percutaneous Ventricular Assist Device Insertion</td>
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<td>CPT 2021</td>
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<tr>
<td>33997</td>
<td>Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion</td>
<td>Oct 2019</td>
<td>Percutaneous Ventricular Assist Device Insertion</td>
<td>05</td>
<td>CPT 2021</td>
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<td>Harvest of Upper Extremity Artery, Endoscopic and Open</td>
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<td>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)</td>
<td>Jan 2017</td>
<td>Treatment of Incompetent Veins</td>
<td>11</td>
<td>CPT 2018</td>
<td>January 2022</td>
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<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers</td>
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<td>36473</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all</td>
<td>Jan 2016</td>
<td>Mechanochemical (MOCA) Vein Ablation</td>
<td>13</td>
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<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all</td>
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<td>Mechanochemical (MOCA) Vein Ablation</td>
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<td>CPT 2017</td>
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<td>Apr 2014</td>
<td>Endovenous Ablation</td>
<td>38</td>
<td>CPT 2015</td>
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<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all</td>
<td>Apr 2014</td>
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<td>38</td>
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<td>January 2022</td>
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<td>Apr 2014</td>
<td>Endovenous Ablation</td>
<td>38</td>
<td>CPT 2015</td>
<td>January 2022</td>
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In October 2018, RUC recommended to review again after 3 more years of data (2022).
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<td>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)</td>
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<td>Endovenous Ablation</td>
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<td>CPT 2015</td>
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<tr>
<td>36482</td>
<td>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</td>
<td>Jan 2017</td>
<td>Treatment of Incompetent Veins</td>
<td>11</td>
<td>CPT 2018</td>
<td>January 2022</td>
<td></td>
</tr>
<tr>
<td>36483</td>
<td>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)</td>
<td>Jan 2017</td>
<td>Treatment of Incompetent Veins</td>
<td>11</td>
<td>CPT 2018</td>
<td>January 2022</td>
<td></td>
</tr>
<tr>
<td>37192</td>
<td>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</td>
<td>Apr 2011</td>
<td>IVC Transcatheter Procedure</td>
<td>12</td>
<td>CPT 2012</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>37193</td>
<td>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</td>
<td>Apr 2011</td>
<td>IVC Transcatheter Procedure</td>
<td>12</td>
<td>CPT 2012</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>37218</td>
<td>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</td>
<td>Apr 2014</td>
<td>Transcatheter Placement of Carotid Stents</td>
<td>12</td>
<td>CPT 2015</td>
<td>October 2018</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>CPT Code</td>
<td>Long Descriptor</td>
<td>Meeting</td>
<td>Issue</td>
<td>Tab</td>
<td>CPT Year</td>
<td>Date to Review</td>
<td>RUC Rec</td>
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<tr>
<td>38220</td>
<td>Diagnostic bone marrow; aspiration(s)</td>
<td>Apr 2016</td>
<td>Diagnostic Bone Marrow Aspiration and Bone Biopsy</td>
<td>06</td>
<td>CPT 2018</td>
<td>January 2022</td>
<td></td>
</tr>
<tr>
<td>38221</td>
<td>Diagnostic bone marrow; biopsy(ies)</td>
<td>Apr 2016</td>
<td>Diagnostic Bone Marrow Aspiration and Bone Biopsy</td>
<td>06</td>
<td>CPT 2018</td>
<td>January 2022</td>
<td></td>
</tr>
<tr>
<td>38222</td>
<td>Diagnostic bone marrow; biopsy(ies) and aspiration(s)</td>
<td>Apr 2016</td>
<td>Diagnostic Bone Marrow Aspiration and Bone Biopsy</td>
<td>06</td>
<td>CPT 2018</td>
<td>January 2022</td>
<td></td>
</tr>
<tr>
<td>38900</td>
<td>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)</td>
<td>Apr 2010</td>
<td>Sentinel Lymph Node Mapping</td>
<td>8</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense</td>
</tr>
<tr>
<td>43180</td>
<td>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</td>
<td>Jan 2014</td>
<td>Endoscopic Hypopharyngeal Diverticulotomy</td>
<td>7</td>
<td>CPT 2015</td>
<td>October 2018</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense</td>
</tr>
<tr>
<td>43210</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with esophagogastic fundoplasty, partial or complete, includes duodenoscopy when performed</td>
<td>Apr 2015</td>
<td>Esophagogastic Fundoplasty Trans-Oral Approach</td>
<td>05</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense</td>
</tr>
<tr>
<td>43273</td>
<td>Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)</td>
<td>Apr 2008</td>
<td>Cholangioscopy-Pancreatoscopy</td>
<td>13</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Specialty to survey Feb 2013 with family of services</td>
</tr>
<tr>
<td>43279</td>
<td>Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed</td>
<td>Apr 2008</td>
<td>Laparoscopic Heller Myotomy</td>
<td>12</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>43281</td>
<td>Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh</td>
<td>Apr 2009</td>
<td>Laparoscopic Paraesophageal Hernia Repair</td>
<td>12</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense</td>
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<td>RUC Rec</td>
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<tr>
<td>43282</td>
<td>Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh</td>
<td>Apr 2009</td>
<td>Laparoscopic Paraesophageal Hernia Repair</td>
<td>12</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
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<tr>
<td>43284</td>
<td>Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed</td>
<td>Jan 2016</td>
<td>Esophageal Sphincter Augmentation</td>
<td>17</td>
<td>January 2024</td>
<td>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.</td>
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<tr>
<td>43285</td>
<td>Removal of esophageal sphincter augmentation device</td>
<td>Jan 2016</td>
<td>Esophageal Sphincter Augmentation</td>
<td>17</td>
<td>CPT 2017</td>
<td>January 2024</td>
<td>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.</td>
</tr>
<tr>
<td>434XX</td>
<td></td>
<td>Oct 2020</td>
<td>Per-Oral Endoscopic Myotomy (POEM)</td>
<td>07</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td></td>
</tr>
<tr>
<td>43647</td>
<td>Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum</td>
<td>Apr 2006</td>
<td>Gastric Antrum Neurostimulation</td>
<td>26</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>43648</td>
<td>Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum</td>
<td>Apr 2006</td>
<td>Gastric Antrum Neurostimulation</td>
<td>26</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>43775</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)</td>
<td>Apr 2009</td>
<td>Laparoscopic Longitudinal Gastrectomy</td>
<td>14</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, carrier priced.</td>
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<tr>
<td>43881</td>
<td>Implantation or replacement of gastric neurostimulator electrodes, antrum, open</td>
<td>Apr 2006</td>
<td>Gastric Antrum Neurostimulation</td>
<td>26</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>43882</td>
<td>Revision or removal of gastric neurostimulator electrodes, antrum, open</td>
<td>Apr 2006</td>
<td>Gastric Antrum Neurostimulation</td>
<td>26</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>43X21</td>
<td>Apr 2021 Endoscopic Bariatric Device Procedures</td>
<td></td>
<td>08 CPT 2023 January 2027</td>
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<tr>
<td>43X22</td>
<td>Apr 2021 Endoscopic Bariatric Device Procedures</td>
<td></td>
<td>08 CPT 2023 January 2027</td>
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<tr>
<td>44705</td>
<td>Apr 2012 Fecal Bacteriotherapy</td>
<td></td>
<td>18 CPT 2013 October 2018</td>
<td></td>
<td></td>
<td>✓</td>
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</tr>
<tr>
<td></td>
<td>Preparation of fecal microbiota for instillation, including assessment of donor specimen</td>
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<tr>
<td>46601</td>
<td>Apr 2014 High Resolution Anoscopy</td>
<td></td>
<td>14 CPT 2015 January 2022</td>
<td></td>
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<tr>
<td></td>
<td>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</td>
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</tbody>
</table>

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 years after additional utilization data is available (October 2018). In October 2018, the RUC recommended to remove from list, no demonstrated technology diffusion that impacts work or practice expense.

In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>RUC Meeting</th>
<th>Issue</th>
<th>CPT Year</th>
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<th>RUC Rec</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>46607</td>
<td>Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple</td>
<td>Apr 2014</td>
<td>High Resolution Anoscopy</td>
<td>14</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).</td>
</tr>
<tr>
<td>46707</td>
<td>Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])</td>
<td>Apr 2009</td>
<td>Fistula Plug</td>
<td>15</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>46948</td>
<td>Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed</td>
<td>Oct 2018</td>
<td>Transanal Hemorrhoidal Dearterialization</td>
<td>07</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>☐</td>
</tr>
<tr>
<td>47383</td>
<td>Ablation, 1 or more liver tumor(s), percutaneous, cryoablation</td>
<td>Apr 2014</td>
<td>Cryoablation of Liver Tumor</td>
<td>15</td>
<td>CPT 2015</td>
<td>October 2018</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>49327</td>
<td>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)</td>
<td>Apr 2010</td>
<td>Fiducial Marker Placement</td>
<td>10</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>49411</td>
<td>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</td>
<td>Apr 2009</td>
<td>Fiducial Marker Placement</td>
<td>6</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
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<td>Issue</td>
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<tr>
<td>49412</td>
<td>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)</td>
<td>Apr 2010</td>
<td>Fiducial Marker Placement 10</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
</tr>
<tr>
<td>49652</td>
<td>Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible</td>
<td>Feb 2011</td>
<td>Laparoscopic Hernia Repair 30</td>
<td>CPT 2009</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
</tr>
<tr>
<td>49653</td>
<td>Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>Feb 2011</td>
<td>Laparoscopic Hernia Repair 30</td>
<td>CPT 2009</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
</tr>
<tr>
<td>49654</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible</td>
<td>Feb 2011</td>
<td>Laparoscopic Hernia Repair 30</td>
<td>CPT 2009</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
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<tr>
<td>49655</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>Feb 2011</td>
<td>Laparoscopic Hernia Repair 30</td>
<td>CPT 2012</td>
<td>October 2015</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✔️</td>
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<tr>
<td>50430</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures 08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>50431</td>
<td>Injection procedure for antegrade nephrostogram and/or ureterogram, complete</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter</td>
<td>08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td></td>
<td>diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy)</td>
<td></td>
<td>Procedures and all associated radiological supervision and interpretation; existing access</td>
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<tr>
<td>50432</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter</td>
<td>08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td></td>
<td>Procedures</td>
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<tr>
<td>50433</td>
<td>Placement of nephroureteral catheter, percutaneous, including diagnostic</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter</td>
<td>08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td></td>
<td>nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access</td>
<td></td>
<td>Procedures and all associated radiological supervision and interpretation</td>
<td></td>
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<tr>
<td>50434</td>
<td>Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter</td>
<td>08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td></td>
<td>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</td>
<td></td>
<td>Procedures</td>
<td></td>
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<tr>
<td>50435</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter</td>
<td>08</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>50593</td>
<td>Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy</td>
<td>Apr 2007</td>
<td>Percutaneous Renal Tumor A</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
<td>✓</td>
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<td></td>
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</tr>
<tr>
<td>50606</td>
<td>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)</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 April 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>50693</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>50694</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>50695</td>
<td>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</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>50705</td>
<td>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)</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>50706</td>
<td>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)</td>
<td>Apr 2015</td>
<td>Genitourinary Catheter Procedures</td>
<td>08</td>
<td>CPT 2016 October 2019</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>☑</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
<td>Complete</td>
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</tr>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant</td>
<td>Apr 2014</td>
<td>Cystourethroscopy Insertion Transprostatic Implant</td>
<td>16</td>
<td>October 2018</td>
<td>Survey for January 2019</td>
<td>✓</td>
</tr>
<tr>
<td>52442</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)</td>
<td>Apr 2014</td>
<td>Cystourethroscopy Insertion Transprostatic Implant</td>
<td>16</td>
<td>October 2018</td>
<td>Survey for January 2019</td>
<td>✓</td>
</tr>
<tr>
<td>53854</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy</td>
<td>Jan 2018</td>
<td>Transurethral Destruction of Prostate Tissue</td>
<td>13</td>
<td>January 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53855</td>
<td>Insertion of a temporary prostatic urethral stent, including urethral measurement</td>
<td>Feb 2009</td>
<td>Temporary Prostatic Urethral Stent Insertion</td>
<td>12</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense</td>
<td>✓</td>
</tr>
<tr>
<td>53860</td>
<td>Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence</td>
<td>Apr 2010</td>
<td>Transurethral Radiofrequency Bladder Neck and Urethra</td>
<td>12</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense</td>
<td>✓</td>
</tr>
<tr>
<td>55706</td>
<td>Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance</td>
<td>Apr 2008</td>
<td>Saturation Biopsies</td>
<td>15</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense</td>
<td>✓</td>
</tr>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed</td>
<td>Oct 2009</td>
<td>Laparoscopic Radical Prostatectomy</td>
<td>14</td>
<td>September 2014</td>
<td>Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time</td>
<td>✓</td>
</tr>
<tr>
<td>55874</td>
<td>Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed</td>
<td>Jan 2017</td>
<td>Peri-Prostatic Implantation of Biodegradable Material</td>
<td>13</td>
<td>January 2022</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
<td>Complete</td>
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</tr>
<tr>
<td>55880</td>
<td>Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance</td>
<td>Oct 2019</td>
<td>Transrectal High Intensity Focused US Prostate Ablation</td>
<td>06</td>
<td>January 2025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57423</td>
<td>Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach</td>
<td>Apr 2007</td>
<td>Laparoscopic Paravaginal Defect Repair</td>
<td>C</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
<td>✓</td>
</tr>
<tr>
<td>57425</td>
<td>Laparoscopy, surgical, colpopexy (suspension of vaginal apex)</td>
<td>Oct 2008</td>
<td>Laparoscopic Revision of Prosthetic Vaginal Graft</td>
<td>7</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✓</td>
</tr>
<tr>
<td>57426</td>
<td>Revision (including removal) of prosthetic vaginal graft, laparoscopic approach</td>
<td>Oct 2008</td>
<td>Laparoscopic Revision of Prosthetic Vaginal Graft</td>
<td>7</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
<td>✓</td>
</tr>
<tr>
<td>57465</td>
<td>Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhiteing effect (List separately in addition to code for primary procedure)</td>
<td>Jan 2020</td>
<td>Computer-Aided Mapping of Cervix Uteri</td>
<td>14</td>
<td>January 2025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;</td>
<td>Feb 2006</td>
<td>Laparoscopic Supracervical Hysterectomy</td>
<td>13</td>
<td>September 2013</td>
<td>Survey April 2014</td>
<td>✓</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
<td>Feb 2006</td>
<td>Laparoscopic Supracervical Hysterectomy</td>
<td>13</td>
<td>September 2013</td>
<td>Survey April 2014</td>
<td>✓</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;</td>
<td>Feb 2006</td>
<td>Laparoscopic Supracervical Hysterectomy</td>
<td>13</td>
<td>September 2013</td>
<td>Survey April 2014</td>
<td>✓</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
<td>Feb 2006</td>
<td>Laparoscopic Supracervical Hysterectomy</td>
<td>13</td>
<td>September 2013</td>
<td>Survey April 2014</td>
<td>✓</td>
</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;</td>
<td>Apr 2007</td>
<td>Laparoscopic Total Hysterectomy</td>
<td>D</td>
<td>September 2013</td>
<td>Survey April 2014</td>
<td>✓</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>Tab</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
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<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
<td>Apr 2007</td>
<td>Laparoscopic Total Hysterectomy</td>
<td>D</td>
<td>CPT 2008</td>
<td>September 2013</td>
<td>Survey April 2014</td>
</tr>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;</td>
<td>Apr 2007</td>
<td>Laparoscopic Total Hysterectomy</td>
<td>D</td>
<td>CPT 2008</td>
<td>September 2013</td>
<td>Survey April 2014</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
<td>Apr 2007</td>
<td>Laparoscopic Total Hysterectomy</td>
<td>D</td>
<td>CPT 2008</td>
<td>September 2013</td>
<td>Survey April 2014</td>
</tr>
<tr>
<td>58674</td>
<td>Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency</td>
<td>Jan 2016</td>
<td>Laparoscopic Radiofrequency Ablation of Uterine Fibroids</td>
<td>18</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>61645</td>
<td>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)</td>
<td>Apr 2015</td>
<td>Intracranial Endovascular Intervention</td>
<td>09</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list. Although the RUC discussed that the subsequent hospital visit occurs, CMS has already issued their statement on 23-hr hospital stay services.</td>
</tr>
<tr>
<td>61650</td>
<td>Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory</td>
<td>Apr 2015</td>
<td>Intracranial Endovascular Intervention</td>
<td>09</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list. Although the RUC discussed that the subsequent hospital visit occurs, CMS has already issued their statement on 23-hr hospital stay services.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
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<tr>
<td>61651</td>
<td>Intracranial Endovascular Intervention</td>
<td>Apr 2015</td>
<td>Intracranial Endovascular Intervention</td>
<td>09</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list. Although the RUC discussed that the subsequent hospital visit occurs, CMS has already issued their statement on 23-hr hospital stay services.</td>
</tr>
<tr>
<td>617X1</td>
<td>Intracranial Laser Interstitial Thermal Therapy (LITT)</td>
<td>Jan 2021</td>
<td>Intracranial Laser Interstitial Thermal Therapy (LITT)</td>
<td>12</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td>⬜️</td>
</tr>
<tr>
<td>617X2</td>
<td>Intracranial Laser Interstitial Thermal Therapy (LITT)</td>
<td>Jan 2021</td>
<td>Intracranial Laser Interstitial Thermal Therapy (LITT)</td>
<td>12</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td>⬜️</td>
</tr>
<tr>
<td>62328</td>
<td>Lumbar Puncture</td>
<td>Jan 2019</td>
<td>Lumbar Puncture</td>
<td>09</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>⬜️</td>
</tr>
<tr>
<td>62329</td>
<td>Lumbar Puncture</td>
<td>Jan 2019</td>
<td>Lumbar Puncture</td>
<td>09</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>⬜️</td>
</tr>
<tr>
<td>62380</td>
<td>Endoscopic Decompression of Spinal Cord, Nerve Root(s), Including Laminotomy, Partial Facetectomy, Foraminotomy, Discectomy and/or Excision of Herniated Intervertebral Disc, 1 Interspace, Lumbar</td>
<td>Jan 2016</td>
<td>Endoscopic Decompression of Spinal Cord Nerve</td>
<td>19</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>63620</td>
<td>Stereotactic Radiosurgery (Particle Beam, Gamma Ray, or Linear Accelerator); 1 Spinal Lesion</td>
<td>Apr 2008</td>
<td>Stereotactic Radiosurgery</td>
<td>16</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>63621</td>
<td>Stereotactic Radiosurgery (Particle Beam, Gamma Ray, or Linear Accelerator); Each Additional Spinal Lesion (List Separately in Addition to Code for Primary Procedure)</td>
<td>Apr 2008</td>
<td>Stereotactic Radiosurgery</td>
<td>16</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>64450</td>
<td>Genicular Injection and RFA</td>
<td>Jan 2019</td>
<td>Genicular Injection and RFA</td>
<td>10</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>⬜️</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec Complete</td>
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<tr>
<td>64451</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)</td>
<td>Jan 2019</td>
<td>Radiofrequency Neurotomy Sacroiliac Joint</td>
<td>08</td>
<td>CPT 2020 January 2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64454</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed</td>
<td>Jan 2019</td>
<td>Genicular Injection and RFA 10</td>
<td>10</td>
<td>CPT 2020 January 2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64566</td>
<td>Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming</td>
<td>Apr 2010</td>
<td>Posterior Tibial Nerve Stimulation</td>
<td>13</td>
<td>CPT 2011 October 2019</td>
<td>✔</td>
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<td></td>
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<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64569</td>
<td>Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator</td>
<td>Feb 2010</td>
<td>Vagus Nerve Stimulator</td>
<td>14</td>
<td>CPT 2011 September 2014</td>
<td>✔</td>
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<td></td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64570</td>
<td>Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
<td>Feb 2010</td>
<td>Vagus Nerve Stimulator</td>
<td>14</td>
<td>CPT 2011 September 2014</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64624</td>
<td>Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed</td>
<td>Jan 2019</td>
<td>Genicular Injection and RFA 10</td>
<td>10</td>
<td>CPT 2020 January 2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64625</td>
<td>Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)</td>
<td>Jan 2019</td>
<td>Radiofrequency Neurotomy Sacroiliac Joint</td>
<td>08</td>
<td>CPT 2020 January 2024</td>
<td></td>
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<tr>
<td>CPT Code</td>
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<td>RUC Meeting</td>
<td>Issue</td>
<td>Tab</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
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</tr>
<tr>
<td>64640</td>
<td>Destruction by neurolytic agent; other peripheral nerve or branch</td>
<td>Jan 2019</td>
<td>Genicular Injection and RFA</td>
<td>10</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td></td>
</tr>
<tr>
<td>646X0</td>
<td>Jan 2021</td>
<td>Destruction of Intraosseous Basivertebral Nerve</td>
<td>14</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>646X1</td>
<td>Jan 2021</td>
<td>Destruction of Intraosseous Basivertebral Nerve</td>
<td>14</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65756</td>
<td>Keratoplasty (corneal transplant); endothelial</td>
<td>Apr 2008</td>
<td>Endothelial Keratoplasty</td>
<td>20</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>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.</td>
</tr>
<tr>
<td>65757</td>
<td>Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)</td>
<td>Apr 2008</td>
<td>Endothelial Keratoplasty</td>
<td>20</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Remove, code does not need to be re-evaluated.</td>
</tr>
<tr>
<td>65779</td>
<td>Placement of amniotic membrane on the ocular surface; single layer, sutured</td>
<td>Feb 2010</td>
<td>Amniotic Membrane Placement</td>
<td>15</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Survey for April 2015.</td>
</tr>
<tr>
<td>65785</td>
<td>Implantation of intrastromal corneal ring segments</td>
<td>Jan 2015</td>
<td>Intrastomal Corneal Ring Implantation</td>
<td>11</td>
<td>CPT 2016</td>
<td>October 2019</td>
<td>Remove from list , no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
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<tr>
<td>66174</td>
<td>Transluminal dilation of aqueous outflow canal; without retention of device or stent</td>
<td>Apr 2010</td>
<td>Open Angle Glaucoma Procedures</td>
<td>15 CPT 2011</td>
<td>October 2019</td>
<td>Jan 2020 - Referred to CPT</td>
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<tr>
<td>66175</td>
<td>Transluminal dilation of aqueous outflow canal; with retention of device or stent</td>
<td>Apr 2010</td>
<td>Open Angle Glaucoma Procedures</td>
<td>15 CPT 2011</td>
<td>October 2019</td>
<td>Jan 2020 - Referred to CPT</td>
<td>✓</td>
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<tr>
<td>66183</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach</td>
<td>Apr 2013</td>
<td>Insertion of Anterior Segment</td>
<td>14 CPT 2014</td>
<td>October 2017</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>66982</td>
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<td>Cataract Removal with Drainage Device Insertion</td>
<td>16 CPT 2022</td>
<td>January 2026</td>
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<td>16 CPT 2022</td>
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<td>Jan 2021</td>
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<tr>
<td>68816</td>
<td>Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation</td>
<td>Apr 2007</td>
<td>Nasolacrimal Duct Balloon Catheter Dilation</td>
<td>E CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<td>68XXX</td>
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<td>Jan 2021</td>
<td>Lacrimal Canaliculus Drug Eluting Implant Insertion</td>
<td>17 CPT 2022</td>
<td>January 2026</td>
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<tr>
<td>69705</td>
<td>Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral</td>
<td>Jan 2020</td>
<td>Dilation of Eustachian Tube</td>
<td>15 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>69706</td>
<td>Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral</td>
<td>Jan 2020</td>
<td>Dilation of Eustachian Tube</td>
<td>15 CPT 2021</td>
<td>January 2025</td>
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<td>70554</td>
<td>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</td>
<td>Feb 2006</td>
<td>Functional MRI</td>
<td>15</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>70555</td>
<td>Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing</td>
<td>Feb 2006</td>
<td>Functional MRI</td>
<td>15</td>
<td>CPT 2007</td>
<td>September 2010</td>
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<td>71271</td>
<td>Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)</td>
<td>Oct 2019</td>
<td>Screening CT of Thorax</td>
<td>07</td>
<td>CPT 2021</td>
<td>January 2025</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>74261</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material</td>
<td>Apr 2009</td>
<td>CT Colonography</td>
<td>19</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>74262</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed</td>
<td>Apr 2009</td>
<td>CT Colonography</td>
<td>19</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>74263</td>
<td>Computed tomographic (CT) colonography, screening, including image postprocessing</td>
<td>Apr 2009</td>
<td>CT Colonography</td>
<td>19</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
</tr>
<tr>
<td>75557</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material</td>
<td>Apr 2007</td>
<td>Cardiac MRI</td>
<td>F</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, as utilization is appropriate due to shift of utilization for deleted code which included &quot;with flow/velocity quantification&quot;, code 75558.</td>
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<tr>
<td>75559</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging</td>
<td>Apr 2007</td>
<td>Cardiac MRI</td>
<td>F</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>75561</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging</td>
<td>Apr 2007</td>
<td>Cardiac MRI</td>
<td>F</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, as utilization is appropriate due to shift of utilization for deleted code which included &quot;with flow/velocity quantification&quot;, code 75560.</td>
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<tr>
<td>75563</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging</td>
<td>Apr 2007</td>
<td>Cardiac MRI</td>
<td>F</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>75571</td>
<td>Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium</td>
<td>Feb 2009</td>
<td>Coronary Computed Tomographic Angiography</td>
<td>15</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<tr>
<td>75572</td>
<td>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)</td>
<td>Feb 2009</td>
<td>Coronary Computed Tomographic Angiography</td>
<td>15</td>
<td>CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
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<tr>
<td>75573</td>
<td>Computed tomography, heart, with contrast material, for evaluation of cardiac</td>
<td>Feb 2009</td>
<td>Coronary Computed Tomographic Angiography</td>
<td>15</td>
<td>September 2013</td>
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<tr>
<td></td>
<td>structure and morphology in the setting of congenital heart disease (including</td>
<td></td>
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<tr>
<td></td>
<td>3D image postprocessing, assessment of LV cardiac function, RV structure</td>
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<td></td>
<td>and function and evaluation of venous structures, if performed)</td>
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<tr>
<td>75574</td>
<td>Computed tomographic angiography, heart, coronary arteries and bypass grafts (</td>
<td>Feb 2009</td>
<td>Coronary Computed Tomographic Angiography</td>
<td>15</td>
<td>September 2013</td>
<td></td>
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<tr>
<td></td>
<td>when present), with contrast material, including 3D image postprocessing (</td>
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<tr>
<td></td>
<td>(including evaluation of cardiac structure and morphology, assessment of</td>
<td></td>
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<td></td>
<td>cardiac function, and evaluation of venous structures, if performed)</td>
<td></td>
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<tr>
<td>76391</td>
<td>Magnetic resonance (eg, vibration) elastography</td>
<td>Jan 2018</td>
<td>Magnetic Resonance Elastography</td>
<td>16</td>
<td>January 2023</td>
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<td>CPT Year</td>
<td>Date to Re-Review</td>
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</tr>
<tr>
<td>76881</td>
<td>Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation</td>
<td>Apr 2010</td>
<td>Ultrasound of Extremity</td>
<td>17</td>
<td>CPT 2011</td>
<td>January 2022</td>
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</tbody>
</table>

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.
<table>
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<tr>
<th>CPT Code</th>
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<th>RUC Meeting</th>
<th>Issue</th>
<th>CPT Year</th>
<th>Date to Re-Review</th>
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<th>Complete</th>
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<tbody>
<tr>
<td>76882</td>
<td>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</td>
<td>Apr 2010</td>
<td>Ultrasound of Extremity</td>
<td>17</td>
<td>CPT 2011</td>
<td>January 2022</td>
<td>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.</td>
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<tr>
<td>76978</td>
<td>Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion</td>
<td>Jan 2018</td>
<td>Contrast-Enhanced Ultrasound</td>
<td>15</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<td>RUC Meeting</td>
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<tr>
<td>76979</td>
<td>Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)</td>
<td>Jan 2018</td>
<td>Contrast-Enhanced Ultrasound</td>
<td>15</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>76981</td>
<td>Ultrasound, elastography; parenchyma (eg, organ)</td>
<td>Jan 2018</td>
<td>Ultrasound Elastography</td>
<td>14</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>76982</td>
<td>Ultrasound, elastography; first target lesion</td>
<td>Jan 2018</td>
<td>Ultrasound Elastography</td>
<td>14</td>
<td>CPT 2019</td>
<td>January 2023</td>
<td></td>
</tr>
<tr>
<td>76983</td>
<td>Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)</td>
<td>Jan 2018</td>
<td>Ultrasound Elastography</td>
<td>14</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77021</td>
<td>Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation</td>
<td>Jan 2018</td>
<td>Fine Needle Aspiration</td>
<td>04</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77046</td>
<td>Magnetic resonance imaging, breast, without contrast material; unilateral</td>
<td>Oct 2017</td>
<td>Breast MRI with Computer-Aided Detection</td>
<td>06</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77047</td>
<td>Magnetic resonance imaging, breast, without contrast material; bilateral</td>
<td>Oct 2017</td>
<td>Breast MRI with Computer-Aided Detection</td>
<td>06</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77048</td>
<td>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</td>
<td>Oct 2017</td>
<td>Breast MRI with Computer-Aided Detection</td>
<td>06</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77049</td>
<td>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</td>
<td>Oct 2017</td>
<td>Breast MRI with Computer-Aided Detection</td>
<td>06</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>77061</td>
<td>Diagnostic digital breast tomosynthesis; unilateral</td>
<td>Apr 2014</td>
<td>Breast Tomosynthesis</td>
<td>19</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>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).</td>
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<tr>
<td>77062</td>
<td>Diagnostic digital breast tomosynthesis; bilateral</td>
<td>Apr 2014</td>
<td>Breast Tomosynthesis</td>
<td>19</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>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).</td>
</tr>
<tr>
<td>77063</td>
<td>Screening digital breast tomosynthesis, bilateral</td>
<td>Apr 2014</td>
<td>Breast Tomosynthesis</td>
<td>19</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>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).</td>
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<tr>
<td>77293</td>
<td>Respiratory motion management simulation</td>
<td>Jan 2013</td>
<td>Respiratory Motion Management Simulation</td>
<td>14</td>
<td>CPT 2014</td>
<td>October 2020</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>77371</td>
<td>Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based</td>
<td>Sep 2005</td>
<td>Stereotactic Radiation Tx Delivery</td>
<td>7</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>77372</td>
<td>Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based</td>
<td>Sep 2005</td>
<td>Stereotactic Radiation Tx Delivery</td>
<td>7</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>77373</td>
<td>Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions</td>
<td>Apr 2006</td>
<td>Stereotactic Body Radiation B Therapy</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Practice expense review (Feb 2011).</td>
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<tr>
<td>77435</td>
<td>Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions</td>
<td>Apr 2006</td>
<td>Stereotactic Body Radiation B Therapy</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Survey (work) and PE review (Feb 2011).</td>
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<tr>
<td>77435</td>
<td>Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions</td>
<td>Feb 2011</td>
<td>Stereotactic Body Radiation Delivery</td>
<td>32</td>
<td>CPT 2012</td>
<td>October 2015</td>
<td>Practice expense review (Feb 2011).</td>
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<tr>
<td>77520</td>
<td>Proton treatment delivery; simple, without compensation</td>
<td>Apr 2019</td>
<td>Proton Beam Treatment Delivery (PE Only)</td>
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<td>Proton treatment delivery; simple, with compensation</td>
<td>Apr 2019</td>
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<td>77523</td>
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<td>77525</td>
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| 77X04    | Trabecular Bone Score (TBS)   | Jan 2021    | 19          | CPT 2022 | January 2026 | ☐
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<tr>
<td>78071</td>
<td>Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)</td>
<td>Apr 2012</td>
<td>Parathyroid Imaging</td>
<td>23</td>
<td>CPT 2013</td>
<td>October 2018</td>
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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
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.
<table>
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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.
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<tr>
<td>78072</td>
<td>Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization</td>
<td>Apr 2012</td>
<td>Parathyroid Imaging</td>
<td>23</td>
<td>CPT 2013</td>
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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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<td>78265</td>
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<td>Apr 2015</td>
<td>Colon Transit Imaging</td>
<td>18 CPT 2016</td>
<td>October 2019</td>
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<tr>
<td>78266</td>
<td>Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days</td>
<td>Apr 2015</td>
<td>Colon Transit Imaging</td>
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<td>October 2019</td>
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<tr>
<td>78429</td>
<td>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</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
<td>13 CPT 2020</td>
<td>January 2024</td>
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</tr>
<tr>
<td>78430</td>
<td>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</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
<td>13 CPT 2020</td>
<td>January 2024</td>
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</tr>
<tr>
<td>78431</td>
<td>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</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
<td>13 CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>78432</td>
<td>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 (e.g., myocardial viability);</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
<td>13</td>
<td>CPT 2020</td>
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<tr>
<td>78433</td>
<td>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 (e.g., myocardial viability); with concurrently acquired computed tomography transmission scan</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
<td>13</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>78434</td>
<td>Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)</td>
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<tr>
<td>78459</td>
<td>Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;</td>
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<tr>
<td>78491</td>
<td>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)</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
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<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>78492</td>
<td>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)</td>
<td>Jan 2019</td>
<td>Myocardial PET</td>
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<tr>
<td>78811</td>
<td>Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)</td>
<td>Apr 2007</td>
<td>PET Imaging</td>
<td>G</td>
<td>CPT 2008</td>
<td>September 2013</td>
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Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
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<td>78812</td>
<td>Positron emission tomography (PET) imaging; skull base to mid-thigh</td>
<td>Apr 2007</td>
<td>PET Imaging</td>
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<td>CPT 2008</td>
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<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)</td>
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<td>PET Imaging</td>
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<td>CPT 2008</td>
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<td>78815</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh</td>
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<td>78816</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body</td>
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<td>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</td>
<td>Jan 2019</td>
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<td>CPT 2020</td>
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<tr>
<td>78831</td>
<td>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</td>
<td>Jan 2019</td>
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<td>78832</td>
<td>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</td>
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<td>Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)</td>
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<td>81161</td>
<td>DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed</td>
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<td>81201</td>
<td>APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence</td>
<td>Apr 2012</td>
<td>Molecular Pathology-Adenomatous Polyposis Coli</td>
<td>24</td>
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<td>Apr 2012</td>
<td>Molecular Pathology-Adenomatous Polyposis Coli</td>
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<tr>
<td>81203</td>
<td>APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants</td>
<td>Apr 2012</td>
<td>Molecular Pathology - Adenomatous Polyposis Coli</td>
<td>24</td>
<td>CPT 2013</td>
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<td>81206</td>
<td>BCR/ABL1 ((t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative</td>
<td>Apr 2011</td>
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<td>CPT 2012</td>
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<td>81210</td>
<td>BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1 05</td>
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<td>BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis</td>
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<tr>
<td>81217</td>
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<td>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)</td>
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<tr>
<td>81222</td>
<td>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants</td>
<td>Apr 2011</td>
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<td>CPT 2012</td>
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<tr>
<td>81223</td>
<td>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1</td>
<td>15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81224</td>
<td>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1</td>
<td>15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81235</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81240</td>
<td>F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G&gt;A variant</td>
<td>Apr 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>15</td>
<td>CPT 2012</td>
<td>October 2015</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81241</td>
<td>F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant</td>
<td>Apr 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>15</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81243</td>
<td>FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81244</td>
<td>FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81245</td>
<td>FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81252</td>
<td>GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81253</td>
<td>GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81254</td>
<td>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)])</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81256</td>
<td>HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1</td>
<td>15</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81257</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81261</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81262</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81263</td>
<td>IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
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<tr>
<td>81264</td>
<td>IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81265</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
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<tr>
<td>81266</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012 October 2015</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<td>81267</td>
<td>Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81268</td>
<td>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</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81270</td>
<td>JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>05</td>
<td>CPT 2012</td>
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<tr>
<td>81275</td>
<td>KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81291</td>
<td>MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81292</td>
<td>MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81293</td>
<td>MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81294</td>
<td>MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81295</td>
<td>MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81296</td>
<td>MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
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<tr>
<td>81297</td>
<td>MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81298</td>
<td>MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
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<tr>
<td>81299</td>
<td>MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81300</td>
<td>MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81301</td>
<td>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</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81302</td>
<td>MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81303</td>
<td>MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81304</td>
<td>MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81315</td>
<td>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</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81316</td>
<td>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</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 1 15</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81317</td>
<td>PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
<td>CPT 2012</td>
<td>Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.</td>
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<tr>
<td>81318</td>
<td>PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81319</td>
<td>PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>81321</td>
<td>PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81322</td>
<td>PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
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<td>81323</td>
<td>PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2016</td>
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<td>81331</td>
<td>SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
<td>05</td>
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<td>81332</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>81340</td>
<td>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)</td>
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<td>81341</td>
<td>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)</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<tr>
<td>81342</td>
<td>TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)</td>
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<td>CPT 2012</td>
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<td>81355</td>
<td>VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G&gt;A, c.173+1000C&gt;T)</td>
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<td>81370</td>
<td>HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1</td>
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<td>81371</td>
<td>HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)</td>
<td>Sep 2011</td>
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<td>81372</td>
<td>HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)</td>
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<td>81374</td>
<td>HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each</td>
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<td>81375</td>
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<td>Molecular Pathology Test - Tier 1</td>
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<td>81376</td>
<td>HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each</td>
<td>Sep 2011</td>
<td>Molecular Pathology Test - Tier 1</td>
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<td>81377</td>
<td>HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each</td>
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<td>81381</td>
<td>HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each</td>
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<td>81382</td>
<td>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</td>
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<td>81383</td>
<td>HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each</td>
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<td>81400</td>
<td>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&gt;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&gt;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), Y34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G&gt;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&gt;T variant NEB (nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), R248X variant...</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 2 16</td>
<td>CPT 2012</td>
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<td>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</td>
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| 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) 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 tumor)                                                                 | 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.
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|          | 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 II]) 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, 2282del14, 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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<td>protein coding</td>
<td>(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)</td>
<td>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</td>
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<td>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&gt;G, m.8993T&gt;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&gt;A, m.3460G&gt;A, m.14484T&gt;C) MT-ND5 (mitochondrially encoded tRNA leucine 1 [UIUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A&gt;G, m.3271T&gt;C, m.3252A&gt;G, m.13513G&gt;A) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), common variants (eg, m.1555A&gt;G, m.1494C&gt;T) MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A&gt;G, m.8356T&gt;C) MT-TL1 (mitochondrially encoded tRNA leucine 1 [UIUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A&gt;G, m.14709 T&gt;C) MT-TL1 MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN],</td>
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<td>mitochondrially encoded 12S RNA (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A&gt;G, m.1555A&gt;G)</td>
<td>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)</td>
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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, glioma 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 [235N, 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, M684V, 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

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**CPT Code** | **Long Descriptor** |
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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, glioma 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 [235N, 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, M684V, 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 |

**RUC** | **Meeting** | **Issue** | **Tab** | **CPT Year** | **Date to Review** | **RUC Rec** | **Complete** |
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| | Apr 2011 | Molecular Pathology - Tier 2 16 | | | | | |

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<td>81403</td>
<td>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of &gt;10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angioenin, 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.1668delT) 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</td>
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| [Scianna blood group], RHCE [Rh blood group, CcEe antigens], KEL [Kell blood group], DARC [Duffy blood group], GYP A, GYP B, 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),
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<td>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)</td>
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<td>81404</td>
<td>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 Va 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,</td>
<td>Apr 2011</td>
<td>Molecular Pathology - Tier 2 16</td>
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<td>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, craniostenosis, 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</td>
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|          | 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 1) (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
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<td>receptor subfamily 0, group B, member 1</td>
<td>(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 dystrophy 2A/B), duplication/deletion analysis SF3B1 (splicing factor, 3b, subunit 1) (eg, Spastic paraplegia 6)</td>
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<td>dystrophy), duplication/deletion analysis SH2D1A (SH2 domain containing 1A)</td>
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<td>(SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thymoprine 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</td>
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<td>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</td>
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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 (apraxatin) (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 sequence...
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 isoenzyme, 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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<td>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, mucopolysaccharidosis, type II), full gene sequence IL2RG (interleukin 2 receptor, gamma) (eg, X-linked severe combined immunodeficiency), full gene sequence ISPD (isoprenoid synthase</td>
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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 1) (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 NDUFS1 (NADH dehydrogenase [ubiquinone] flavoprotein 1, 51kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence...
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| 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 PQQBP1 (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...
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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<td>hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of &gt;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</td>
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<td>81406</td>
<td>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 ALDH7A1 (aldehyde dehydrogenase 7 family, member A1) (eg, pyridoxine-dependent epilepsy), full gene sequence ANOS (anocytin 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</td>
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<td>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/cardiomopathy 11), full gene sequence DSG2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomopathy 10), full gene sequence</td>
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<td>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 (fumarylacetoacetase 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...</td>
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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 HCPX (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 KCNO1 (potassium voltage-gated channel, KQT-like subfamily, member 1) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNO2 (potassium voltage-gated channel, KQT-like subfamily, member 2) (eg,
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 LHCG (luteining 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 (methylcrotonyl-CoA
carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-CoA
carboxylase deficiency), full gene sequence
MCCC2 (methylcrotonyl-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
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
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| 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
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<td>SETX</td>
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<td>SGCE</td>
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<td>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 isothenuria), 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</td>
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<td>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of &gt;50 exons, sequence analysis of multiple genes on one platform) ABCBC8 (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 AH11 (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 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...</td>
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<td>Molecular Pathology - Tier 2 16</td>
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<td>MYH6</td>
<td>(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 PLC1 (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, Gliemman syndrome), full gene sequence SPEG11 (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</td>
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`gene sequence`
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<td>Molecular pathology procedure, Level 9 (eg, analysis of &gt;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), 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 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)</td>
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<td>Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);</td>
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<td>86153</td>
<td>Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required</td>
<td>Apr 2012</td>
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<td>CPT 2013</td>
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<td>88363</td>
<td>Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)</td>
<td>Feb 2010</td>
<td>Archival Retrieval for</td>
<td>CPT 2011</td>
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<td>88375</td>
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<td>Jan 2013</td>
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<td>Microdissection (ie, sample preparation of microscopically identified target); laser capture</td>
<td>Feb 2007</td>
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<td>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)</td>
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<td>Tissue Examination for Molecular Studies</td>
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<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management</td>
<td>Feb 2011</td>
<td>Transcranial Magnetic Stimulation</td>
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<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session</td>
<td>Feb 2011</td>
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<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management</td>
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<td>Transcranial Magnetic Stimulation</td>
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<td>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.</td>
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<td>Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report</td>
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<td>Wireless Motility Capsule</td>
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<td>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</td>
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<td>Colon Motility</td>
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<td>Apr 2010</td>
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<td>Apr 2010</td>
<td>Computerized Scanning Ophthalmology Diagnostic Imaging</td>
<td>23</td>
<td>CPT 2011</td>
<td>September 2014</td>
</tr>
<tr>
<td>92227</td>
<td>Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral</td>
<td>Oct 2019</td>
<td>Remote Retinal Imaging</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
</tr>
<tr>
<td>92228</td>
<td>Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral</td>
<td>Apr 2010</td>
<td>Diabetic Retinopathy Imaging</td>
<td>24</td>
<td>CPT 2011</td>
<td>September 2014</td>
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<tr>
<td>92228</td>
<td>Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral</td>
<td>Oct 2019</td>
<td>Remote Retinal Imaging</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>92229</td>
<td>Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral</td>
<td>Oct 2019</td>
<td>Remote Retinal Imaging</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<td>CPT Code</td>
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<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
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<td>92284</td>
<td>Dark Adaption Eye Exam</td>
<td>Apr 2021</td>
<td>20</td>
<td>CPT 2023</td>
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<tr>
<td>92517</td>
<td>Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)</td>
<td>Apr 2019</td>
<td>Vestibular Evoked Myogenic Potential (VEMP) Testing</td>
<td>07</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>92518</td>
<td>Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)</td>
<td>Apr 2019</td>
<td>Vestibular Evoked Myogenic Potential (VEMP) Testing</td>
<td>07</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<td>92519</td>
<td>Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)</td>
<td>Apr 2019</td>
<td>Vestibular Evoked Myogenic Potential (VEMP) Testing</td>
<td>07</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>93050</td>
<td>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</td>
<td>Apr 2015</td>
<td>Arterial Pressure Waveform Analysis</td>
<td>20</td>
<td>CPT 2016</td>
<td>January 2022</td>
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<tr>
<td>93241</td>
<td>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</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>CPT Code</td>
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<td>Date to Re-Review</td>
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<tr>
<td>93242</td>
<td>External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>93243</td>
<td>External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
<td>☐</td>
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<tr>
<td>93244</td>
<td>External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>93245</td>
<td>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</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
<td>☐</td>
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<tr>
<td>93246</td>
<td>External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
<td>☐</td>
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<tr>
<td>93247</td>
<td>External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
<td>☐</td>
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<tr>
<td>93248</td>
<td>External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation</td>
<td>Jan 2020</td>
<td>External Extended ECG Monitoring</td>
<td>18 CPT 2021</td>
<td>January 2025</td>
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<td>93260</td>
<td>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</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable Defibrillator Procedures</td>
<td>09 CPT 2015</td>
<td>January 2022</td>
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In October 2018, RUC recommended to review again after 3 more years of data (2022).
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<th>CPT Code</th>
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<th>Issue</th>
<th>CPT Year</th>
<th>Date to Re-Review</th>
<th>RUC Rec</th>
<th>Complete</th>
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<tbody>
<tr>
<td>93261</td>
<td>Interrogation device evaluation (in person) with analysis, review and report by a</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable Defibrillator</td>
<td>09</td>
<td>January 2022</td>
<td></td>
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<tr>
<td></td>
<td>physician or other qualified health care professional, includes connection,</td>
<td></td>
<td>Procedures</td>
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<td></td>
<td>recording and disconnection per patient encounter; implantable subcutaneous lead</td>
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<td></td>
<td>defibrillator system</td>
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<td>93264</td>
<td>Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30</td>
<td>Jan 2018</td>
<td>Pulmonary Wireless Pressure Sensor Services</td>
<td>08</td>
<td>January 2023</td>
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<td></td>
<td>days, including at least weekly downloads of pulmonary artery pressure recordings,</td>
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<td>interpretation(s), trend analysis, and report(s) by a physician or other qualified</td>
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<td></td>
<td>health care professional</td>
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<td>93279</td>
<td>Programming device evaluation (in person) with iterative adjustment of the</td>
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<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>September 2012</td>
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<td></td>
<td>implantable device to test the function of the device and select optimal</td>
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<td></td>
<td>permanent programmed values with analysis, review and report by a physician or</td>
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<td></td>
<td>other qualified health care professional; single lead pacemaker system or leadless</td>
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<td></td>
<td>pacemaker system in one cardiac chamber</td>
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<td>93280</td>
<td>Programming device evaluation (in person) with iterative adjustment of the</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>September 2012</td>
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<td></td>
<td>implantable device to test the function of the device and select optimal</td>
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<td>permanent programmed values with analysis, review and report by a physician or</td>
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<td></td>
<td>other qualified health care professional; dual lead pacemaker system</td>
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<td>93281</td>
<td>Programming device evaluation (in person) with iterative adjustment of the</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>September 2012</td>
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<tr>
<td></td>
<td>implantable device to test the function of the device and select optimal</td>
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<td>permanent programmed values with analysis, review and report by a physician or</td>
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<td></td>
<td>other qualified health care professional; multiple lead pacemaker system</td>
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<tr>
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<tr>
<td>93282</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
</tr>
<tr>
<td>93283</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<td>93284</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<tr>
<td>93285</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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</table>
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

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

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

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

Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.
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<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>RUC Meeting</th>
<th>Issue</th>
<th>CPT Year</th>
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<th>RUC Rec</th>
<th>Complete</th>
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<tbody>
<tr>
<td>93290</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
</tr>
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<td>93291</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<tr>
<td>93292</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<td>93293</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<td>93294</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<tr>
<td>93295</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<td>93296</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
</tr>
<tr>
<td>93297</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
<td>September 2012</td>
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<td>93298</td>
<td>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</td>
<td>Apr 2008</td>
<td>Cardiac Device Monitoring</td>
<td>23</td>
<td>CPT 2009</td>
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<td>Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.</td>
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<td>Oct 2020</td>
<td>3D Imaging of Cardiac Structures</td>
<td>09</td>
<td>CPT 2022</td>
<td>January 2026</td>
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<tr>
<td>93462</td>
<td>Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)</td>
<td>Apr 2010</td>
<td>Diagnostic Cardiac Catheterization</td>
<td>26</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
</tr>
<tr>
<td>93463</td>
<td>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)</td>
<td>Apr 2010</td>
<td>Diagnostic Cardiac Catheterization</td>
<td>26</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
</tr>
<tr>
<td>93464</td>
<td>Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)</td>
<td>Apr 2010</td>
<td>Diagnostic Cardiac Catheterization</td>
<td>26</td>
<td>CPT 2011</td>
<td>September 2014</td>
<td>Remove from list, no demonstrated technology diffusions that impacts work or practice expense.</td>
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<td>Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed</td>
<td>Jan 2013</td>
<td>Percutaneous Alcohol Ablation of Septum</td>
<td>17</td>
<td>CPT 2014</td>
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<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>Jan 2016</td>
<td>Closure of Paravalvular Leak</td>
<td>22</td>
<td>CPT 2017</td>
<td>October 2020</td>
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<tr>
<td>93591</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve</td>
<td>Jan 2016</td>
<td>Closure of Paravalvular Leak</td>
<td>22</td>
<td>CPT 2017</td>
<td>October 2020</td>
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<td>93592</td>
<td>Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)</td>
<td>Jan 2016</td>
<td>Closure of Paravalvular Leak</td>
<td>22</td>
<td>CPT 2017</td>
<td>October 2020</td>
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<td>93644</td>
<td>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)</td>
<td>Apr 2014</td>
<td>Subcutaneous Implantable Defibrillator Procedures</td>
<td>09</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
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<td>Wireless Pressure Sensor Implantation</td>
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<td>CPT 2008</td>
<td>September 2011</td>
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<td>CPT 2022</td>
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<td>94011</td>
<td>Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age</td>
<td>Apr 2009</td>
<td>Infant Pulmonary Function Testing</td>
<td>23 CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>94012</td>
<td>Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age</td>
<td>Apr 2009</td>
<td>Infant Pulmonary Function Testing</td>
<td>23 CPT 2010</td>
<td>September 2013</td>
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<tr>
<td>94013</td>
<td>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</td>
<td>Apr 2009</td>
<td>Infant Pulmonary Function Testing</td>
<td>23 CPT 2010</td>
<td>September 2013</td>
<td>Remove from list, no demonstrated technology diffusion that impacts work or practice expense.</td>
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<td>946X1</td>
<td>Outpatient Pulmonary Rehabilitation Services</td>
<td>Jan 2021</td>
<td>23 CPT 2022</td>
<td>January 2026</td>
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<td>Outpatient Pulmonary Rehabilitation Services</td>
<td>Jan 2021</td>
<td>23 CPT 2022</td>
<td>January 2026</td>
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<td>95700</td>
<td>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</td>
<td>Oct 2018</td>
<td>Long-Term EEG Monitoring</td>
<td>13 CPT 2020</td>
<td>January 2024</td>
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**Monday, May 10, 2021**  
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<th>RUC Rec</th>
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<td>Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance</td>
<td>Oct 2018</td>
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<td>Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance</td>
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<td>Long-Term EEG Monitoring</td>
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<td>Oct 2018</td>
<td>Long-Term EEG Monitoring</td>
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<td>CPT 2020</td>
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<td>Oct 2018</td>
<td>Long-Term EEG Monitoring</td>
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<td>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</td>
<td>Oct 2018</td>
<td>Long-Term EEG Monitoring</td>
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<td>Oct 2018</td>
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<td>Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time</td>
<td>Apr 2010</td>
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<td>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.</td>
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<td>Sleep Testing</td>
<td>28</td>
<td>CPT 2011</td>
<td>October 2016</td>
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<td>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.</td>
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<td>Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)</td>
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<td>Actigraphy Sleep Assessment</td>
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<td>September 2012</td>
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<td>Sleep Testing</td>
<td>28</td>
<td>October 2016</td>
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<td>Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days</td>
<td>Jan 2018</td>
<td>Electrocorticography</td>
<td>18</td>
<td>January 2023</td>
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<td>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</td>
<td>Feb 2009</td>
<td>Nerve Conduction Tests</td>
<td>18</td>
<td>September 2013</td>
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</tr>
<tr>
<td>95940</td>
<td>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)</td>
<td>Jan 2012</td>
<td>Intraoperative Neurophysiology Monitoring</td>
<td>12</td>
<td>October 2016</td>
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<tr>
<td>95941</td>
<td>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)</td>
<td>Jan 2012</td>
<td>Intraoperative Neurophysiology Monitoring</td>
<td>12</td>
<td>October 2016</td>
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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.

Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
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<tr>
<th>CPT Code</th>
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<th>RUC Meeting</th>
<th>Issue</th>
<th>CPT Year</th>
<th>Date to Re-Review</th>
<th>RUC Rec</th>
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<tbody>
<tr>
<td>95980</td>
<td>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</td>
<td>Apr 2007</td>
<td>Electronic Analysis of Implanted Neurostimulator Pulse Generator System</td>
<td>I</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>95981</td>
<td>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</td>
<td>Apr 2007</td>
<td>Electronic Analysis of Implanted Neurostimulator Pulse Generator System</td>
<td>I</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
</tr>
<tr>
<td>95982</td>
<td>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</td>
<td>Apr 2007</td>
<td>Electronic Analysis of Implanted Neurostimulator Pulse Generator System</td>
<td>I</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>96020</td>
<td>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</td>
<td>Feb 2006</td>
<td>Functional MRI</td>
<td>15</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>96904</td>
<td>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</td>
<td>Feb 2006</td>
<td>Whole Body Integumentary Photography</td>
<td>19</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>96931</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
<td>Issue</td>
<td>CPT Year</td>
<td>Date to Re-Review</td>
<td>RUC Rec</td>
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<tr>
<td>96932</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
</tr>
<tr>
<td>96933</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
</tr>
<tr>
<td>96934</td>
<td>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)</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
</tr>
<tr>
<td>96935</td>
<td>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)</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
</tr>
<tr>
<td>96936</td>
<td>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)</td>
<td>Oct 2015</td>
<td>Reflectance Confocal Microscopy</td>
<td>06</td>
<td>CPT 2017</td>
<td>October 2020</td>
<td>Review in 3 years (October 2023).</td>
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<tr>
<td>97605</td>
<td>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</td>
<td>Jan 2014</td>
<td>Negative Wound Pressure Therapy</td>
<td>17</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
</tr>
<tr>
<td>97606</td>
<td>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</td>
<td>Jan 2014</td>
<td>Negative Wound Pressure Therapy</td>
<td>17</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
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<td>CPT Year</td>
<td>Date to Review</td>
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<tr>
<td>97607</td>
<td>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</td>
<td>Jan 2014</td>
<td>Negative Wound Pressure Therapy</td>
<td>17</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
</tr>
<tr>
<td>97608</td>
<td>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</td>
<td>Jan 2014</td>
<td>Negative Wound Pressure Therapy</td>
<td>17</td>
<td>CPT 2015</td>
<td>January 2022</td>
<td>In October 2018, RUC recommended to review again after 3 more years of data (2022).</td>
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<tr>
<td>97610</td>
<td>Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</td>
<td>Oct 2013</td>
<td>HCPAC - Ultrasonic Wound Assessment</td>
<td>17</td>
<td>CPT 2015</td>
<td>October 2018</td>
<td>Survey for January 2019.</td>
</tr>
<tr>
<td>98966</td>
<td>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</td>
<td>Apr 2007</td>
<td>Non Face-to-Face Qualified U Healthcare Professional Services</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
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<td>CPT Code</td>
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<td>Issue</td>
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<td>Date to Re-Review</td>
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<td>98967</td>
<td>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</td>
<td>Apr 2007</td>
<td>Non Face-to-Face Qualified U Healthcare Professional Services</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
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<tr>
<td>98968</td>
<td>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</td>
<td>Apr 2007</td>
<td>Non Face-to-Face Qualified U Healthcare Professional Services</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
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<tr>
<td>98970</td>
<td>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</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>98971</td>
<td>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</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>98972</td>
<td>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</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>CPT 2020</td>
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<td>989X1</td>
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<td>Jan 2021</td>
<td>Remote Therapeutic Monitoring</td>
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<td>989X4</td>
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<td>989X5</td>
<td>Remote Therapeutic Monitoring</td>
<td>Jan 2021</td>
<td>Remote Therapeutic Monitoring</td>
<td>24 CPT 2022</td>
<td>January 2026</td>
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<tr>
<td>99202</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99203</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99204</td>
<td>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.</td>
<td>Apr 2019</td>
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<td>09 CPT 2021</td>
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<tr>
<td>99205</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99211</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09 CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99212</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99213</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99214</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
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<tr>
<td>99215</td>
<td>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.</td>
<td>Apr 2019</td>
<td>Office Visits</td>
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<td>CPT 2021</td>
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<td>99363</td>
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<td>Apr 2006</td>
<td>Anticoagulant Management I Services</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
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<tr>
<td>99364</td>
<td>Code Deleted</td>
<td>Apr 2006</td>
<td>Anticoagulant Management I Services</td>
<td>CPT 2007</td>
<td>September 2010</td>
<td>Remove, code does not need to be re-evaluated</td>
<td>✔️</td>
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<tr>
<td>99417</td>
<td>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)</td>
<td>Apr 2019</td>
<td>Office Visits</td>
<td>09</td>
<td>CPT 2021</td>
<td>January 2025</td>
<td>□</td>
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<tr>
<td>99421</td>
<td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>21</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>99422</td>
<td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>21</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>□</td>
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<tr>
<td>99423</td>
<td>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</td>
<td>Jan 2019</td>
<td>Online Digital Evaluation Service (e-Visit)</td>
<td>21</td>
<td>CPT 2020</td>
<td>January 2024</td>
<td>□</td>
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<tr>
<td>99439</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25</td>
<td>CPT 2022</td>
<td>January 2026</td>
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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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>RUC Meeting</th>
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<th>Tab</th>
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<th>Complete</th>
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<tr>
<td>99441</td>
<td>Telephone evaluation and management service by a physician or other qualified</td>
<td>Feb 2007</td>
<td>Non Face-to-Face Services</td>
<td>16</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
<td>✓</td>
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<tr>
<td></td>
<td>health care professional who may report evaluation and management services</td>
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<td>provided to an established patient, parent, or guardian not originating from a</td>
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<td>related E/M service provided within the previous 7 days nor leading to an E/M</td>
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<td></td>
<td>service or procedure within the next 24 hours or soonest available appointment;</td>
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<td>5-10 minutes of medical discussion</td>
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<td>99442</td>
<td>Telephone evaluation and management service by a physician or other qualified</td>
<td>Feb 2007</td>
<td>Non Face-to-Face Services</td>
<td>16</td>
<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
<td>✓</td>
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<td></td>
<td>health care professional who may report evaluation and management services</td>
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<td>provided to an established patient, parent, or guardian not originating from a</td>
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<td>related E/M service provided within the previous 7 days nor leading to an E/M</td>
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<td>service or procedure within the next 24 hours or soonest available appointment;</td>
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<td>11-20 minutes of medical discussion</td>
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<td>99443</td>
<td>Telephone evaluation and management service by a physician or other qualified</td>
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<td>Non Face-to-Face Services</td>
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<td>CPT 2008</td>
<td>September 2011</td>
<td>Remove, not covered by Medicare</td>
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<td>health care professional who may report evaluation and management services</td>
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<td>related E/M service provided within the previous 7 days nor leading to an E/M</td>
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<td>service or procedure within the next 24 hours or soonest available appointment;</td>
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<td>21-30 minutes of medical discussion</td>
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<td>management service provided by a consultative physician, including a verbal and</td>
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<td>Telephone Consultative</td>
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<td>written report to the patient's treating/requesting physician or other qualified</td>
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<td>Services</td>
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<td>health care professional; 5-10 minutes of medical consultative discussion and</td>
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<tr>
<td>99447</td>
<td>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</td>
<td>Oct 2012</td>
<td>Interprofessional Telephone Consultative Services</td>
<td>14</td>
<td>CPT 2014 October 2016</td>
<td>Reaffirmed RUC recommendation</td>
<td>✔️</td>
<td></td>
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<tr>
<td>99448</td>
<td>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</td>
<td>Oct 2012</td>
<td>Interprofessional Telephone Consultative Services</td>
<td>14</td>
<td>CPT 2014 October 2016</td>
<td>Reaffirmed RUC recommendation</td>
<td>✔️</td>
<td></td>
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<tr>
<td>99449</td>
<td>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</td>
<td>Oct 2012</td>
<td>Interprofessional Telephone Consultative Services</td>
<td>14</td>
<td>CPT 2014 October 2016</td>
<td>Reaffirmed RUC recommendation</td>
<td>✔️</td>
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<tr>
<td>99451</td>
<td>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</td>
<td>Jan 2018</td>
<td>Interprofessional Internet Consultation</td>
<td>21</td>
<td>CPT 2019 January 2023</td>
<td></td>
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<tr>
<td>99452</td>
<td>Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes</td>
<td>Jan 2018</td>
<td>Interprofessional Internet Consultation</td>
<td>21</td>
<td>CPT 2019 January 2023</td>
<td></td>
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<tr>
<td>99453</td>
<td>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</td>
<td>Jan 2018</td>
<td>Chronic Care Remote Physiologic Monitoring</td>
<td>20</td>
<td>CPT 2019 January 2023</td>
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<td>CPT Code</td>
<td>Long Descriptor</td>
<td>RUC Meeting</td>
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<tr>
<td>99454</td>
<td>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</td>
<td>Jan 2018</td>
<td>Chronic Care Remote Physiologic Monitoring</td>
<td>20</td>
<td>CPT 2019</td>
<td>January 2023</td>
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<tr>
<td>99457</td>
<td>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</td>
<td>Jan 2018</td>
<td>Chronic Care Remote Physiologic Monitoring</td>
<td>20</td>
<td>CPT 2019</td>
<td>January 2024</td>
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<tr>
<td>99458</td>
<td>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)</td>
<td>Jan 2019</td>
<td>Chronic Care Remote Physiologic Monitoring</td>
<td>20</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<tr>
<td>99474</td>
<td>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</td>
<td>Jan 2019</td>
<td>Self-Measured Blood Pressure Monitoring</td>
<td>19</td>
<td>CPT 2020</td>
<td>January 2024</td>
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<td>99484</td>
<td>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.</td>
<td>Jan 2017</td>
<td>Psychiatric Collaborative Care Management Services</td>
<td>20</td>
<td>CPT 2018</td>
<td>January 2022</td>
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<tr>
<td>99487</td>
<td>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.</td>
<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25</td>
<td>CPT 2013</td>
<td>January 2026</td>
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<tr>
<td>99488</td>
<td>Code Deleted</td>
<td>Oct 2012</td>
<td>Complex Chronic Care Coordination Services</td>
<td>09</td>
<td>CPT 2013</td>
<td>October 2017</td>
<td>Code Deleted</td>
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<td>CPT Code</td>
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<tr>
<td>99489</td>
<td>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)</td>
<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25</td>
<td>CPT 2013</td>
<td>January 2026</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>99490</td>
<td>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.</td>
<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25</td>
<td>CPT 2015</td>
<td>January 2026</td>
<td>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.</td>
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<td>99491</td>
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<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25</td>
<td>CPT 2022</td>
<td>January 2026</td>
<td>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.</td>
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<td>99492</td>
<td>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.</td>
<td>Jan 2017</td>
<td>Psychiatric Collaborative Care Management Services</td>
<td>20</td>
<td>CPT 2018</td>
<td>January 2023</td>
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<td>RUC Meeting</td>
<td>Issue Long Descriptor</td>
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<td>Date to Review</td>
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<td>99493</td>
<td>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.</td>
<td>Jan 2017</td>
<td>Psychiatric Collaborative Care Management Services</td>
<td>20</td>
<td>CPT 2018</td>
<td>January 2023</td>
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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
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<th>RUC Rec</th>
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technology/new services review until January 2023, after the CPT Assistant article has time to take effect.
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<th>RUC Rec</th>
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<tr>
<td>99494</td>
<td>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)</td>
<td>Jan 2017</td>
<td>Psychiatric Collaborative Care Management Services</td>
<td>20</td>
<td>CPT 2018</td>
<td>January 2023</td>
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<td>CPT Code</td>
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<td>RUC Meeting</td>
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<td>99495</td>
<td>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</td>
<td>Oct 2012</td>
<td>Transitional Care Management Services</td>
<td>08 CPT 2013</td>
<td>October 2017</td>
<td>Survey for October 2018</td>
<td>✓</td>
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</tr>
<tr>
<td>99496</td>
<td>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</td>
<td>Oct 2012</td>
<td>Transitional Care Management Services</td>
<td>08 CPT 2013</td>
<td>October 2017</td>
<td>Survey for October 2018</td>
<td>✓</td>
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<tr>
<td>99497</td>
<td>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</td>
<td>Jan 2014</td>
<td>Advance Care Planning</td>
<td>19 CPT 2015</td>
<td>January 2022</td>
<td>Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).</td>
<td>□</td>
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<tr>
<td>99498</td>
<td>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)</td>
<td>Jan 2014</td>
<td>Advance Care Planning</td>
<td>19 CPT 2015</td>
<td>January 2022</td>
<td>Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).</td>
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<td>99X21</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>Jan 2021</td>
<td>Principal Care Management (PCM) &amp; Chronic Care Management (CCM)</td>
<td>25 CPT 2022</td>
<td>January 2026</td>
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<td>CPT Code</td>
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<td>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</td>
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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**

- **Apr 2020, Oct 2020, Jan 2021 RUC Mtgs**
  - Code Flagged as New Technology/Service and submitted to CMS with recommendations

- **January 2022**
  - Codes published in CPT 2021 available to be reported

- **January 2022 – December 2024**
  - Three years of data

- **January 2026**
  - 2022-2024 Data available for review (AMA staff will provide data). Specialty societies have the opportunity to discuss whether there has been a diffusion of technology for this service.

- **RUC determines that the service does not need to be evaluated**
  - Code is removed from the New Technology/Services list and will be addressed with all other codes through the potentially misvalued code process if applicable.

- **RUC determines that the service requires additional claims data (more than the first 3 years)**
  - RUC will determine on case-by-case basis when the service should be reviewed again through the New Technology/New Services process

- **RUC determines that the service does need to be evaluated**
  - January 2026 – April 2026
    - Survey New Technology/Service Code
  - April 2026
    - Present New Technology/Service Code to the RUC
  - January 2028
    - New RVU published if approved by the RUC and CMS

*Revised May 2021*
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<td>Arthrodesis, posterior interbody</td>
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<td>22633</td>
<td>Arthrodesis, combined posterior</td>
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<td>22869</td>
<td>Insertion of interlaminar/inters</td>
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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...
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 *Thoracoscopic, 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
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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 fundoplasting, 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 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.
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>22840-22848, 22850, 22852, 22853, 22854, 22859.</td>
<td>20930-20938.</td>
<td>20900-20938.</td>
</tr>
<tr>
<td>Arthrodesis Posterior, Posterolateral or Lateral Transverse Process Technique</td>
<td>To report instrumentation procedures, see 22840-22855. (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.</td>
<td></td>
</tr>
<tr>
<td>Corpectomy</td>
<td>identifies removal of a vertebral body during spinal surgery.</td>
<td></td>
</tr>
<tr>
<td>Facetectomy</td>
<td>is the excision of the facet joint between two vertebral bodies. There are two facet joints at each vertebral segment (see below)</td>
<td></td>
</tr>
<tr>
<td>Foraminotomy</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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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.

<table>
<thead>
<tr>
<th></th>
<th>CPT Code</th>
<th>Description</th>
<th>Value</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e)</td>
<td>22600</td>
<td>Arthrodesis, posterior or posterolateral technique, single-level interspace; cervical below C2 segment</td>
<td>17.40</td>
<td>No change</td>
</tr>
<tr>
<td>(e)</td>
<td>22610</td>
<td>thoracic (with lateral transverse technique, when performed)</td>
<td>17.28</td>
<td>No change</td>
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<tr>
<td>(e)</td>
<td>22612</td>
<td>lumbar (with lateral transverse technique, when performed)</td>
<td>23.53</td>
<td>No change</td>
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<tr>
<td></td>
<td></td>
<td>(Do not report 22612 in conjunction with 22630 for the same interspace and segment, use 22633)</td>
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<td></td>
</tr>
<tr>
<td>(e)</td>
<td>22614</td>
<td>each additional vertebral segment interspace (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>6.43</td>
</tr>
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</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>J1</th>
<th>Description</th>
<th>090</th>
<th>22.09</th>
<th>(No change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1</td>
<td></td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f22630</td>
<td>J2</td>
<td>each additional interspace (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>5.22</td>
<td>(No change)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(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)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▲22633</td>
<td>J3</td>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report with 22612 or 22630 at the same level interspace)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+▲22634</td>
<td>J4</td>
<td>each additional interspace and segment (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>7.96</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Use 22634 in conjunction with 22633)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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...*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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 |
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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>ZZZ</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>63052</td>
<td>J5</td>
<td>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)</td>
<td>ZZZ</td>
<td>5.70</td>
</tr>
<tr>
<td>63053</td>
<td>J6</td>
<td>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)</td>
<td>ZZZ</td>
<td>5.00</td>
</tr>
</tbody>
</table>

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)
<table>
<thead>
<tr>
<th>CPT Code: 22630</th>
<th>Tracking Number: J1</th>
<th>Original Specialty Recommended RVU: 22.09</th>
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<tbody>
<tr>
<td>Global Period: 090</td>
<td>Current Work RVU: 22.09</td>
<td>Presented Recommended RVU: 22.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RUC Recommended RVU: 22.09</td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital 99% , In the ASC 1%, In the office 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 94%</td>
</tr>
</tbody>
</table>

**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 (i.e., 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD</td>
</tr>
<tr>
<td>Specialty Society(les):</td>
<td>AANS, CNS, AAOS, NASS, ISASS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>22630</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2028</td>
</tr>
<tr>
<td>Resp N:</td>
<td>111</td>
</tr>
</tbody>
</table>

**Description of Sample:** random

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>5.00</td>
<td>10.00</td>
<td>33.00</td>
<td>300.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>19.60</td>
<td>25.00</td>
<td>25.52</td>
<td>28.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>48.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>20.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td>120.00</td>
<td>150.00</td>
<td>180.00</td>
<td>270.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Operative Visits Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
<td>99292x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>100.00</td>
<td>99231x</td>
<td>1.00</td>
<td>99232x</td>
<td>2.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>38.00</td>
<td>99238x</td>
<td>1.00</td>
<td>99239x</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>86.00</td>
<td>99211x</td>
<td>0.00</td>
<td>12x</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
<td>55x</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
<td>99225x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>22630</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>22.09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>20.00</td>
<td>3.00</td>
<td>17.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>150.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td>33.00</td>
<td>-3.00</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22533</td>
<td>090</td>
<td>24.79</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22612</td>
<td>090</td>
<td>23.53</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>35301</td>
<td>090</td>
<td>21.16</td>
<td>RUC Time</td>
<td>35,904</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>32669</td>
<td>090</td>
<td>23.53</td>
<td>RUC Time</td>
<td>1,894</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 22630</th>
<th>Top Key Reference CPT Code: 22533</th>
<th>2nd Key Reference CPT Code: 22612</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>75.00</td>
<td>116.00</td>
<td>95.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>150.00</td>
<td>180.00</td>
<td>150.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>38.00</td>
<td>38.00</td>
<td>38.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>86.00</td>
<td>85.00</td>
<td>69.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>479.00</td>
<td>549.00</td>
<td>482.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
*(of those that selected Key Reference codes)*

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>7%</td>
<td>38%</td>
<td>43%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>53%</td>
<td>40%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>50%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Technical skill required
**Physical effort required**

<table>
<thead>
<tr>
<th></th>
<th>3%</th>
<th>43%</th>
<th>53%</th>
</tr>
</thead>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>47%</td>
<td>37%</td>
</tr>
</tbody>
</table>

- 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

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>52%</td>
<td>28%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>24%</td>
<td>76%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4%</td>
<td>24%</td>
<td>72%</td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>36%</td>
<td>64%</td>
</tr>
</tbody>
</table>

- 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

---

**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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPOT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
<td>22.09</td>
<td>0.078</td>
<td>479</td>
<td>75</td>
<td>150</td>
<td>254</td>
</tr>
<tr>
<td>22533</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
<td>24.79</td>
<td>0.076</td>
<td>549</td>
<td>116</td>
<td>180</td>
<td>253</td>
</tr>
<tr>
<td>22612</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</td>
<td>23.53</td>
<td>0.088</td>
<td>482</td>
<td>95</td>
<td>150</td>
<td>237</td>
</tr>
</tbody>
</table>

MPC Code Comparison

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPOT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>35301</td>
<td>Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision</td>
<td>21.16</td>
<td>0.104</td>
<td>404</td>
<td>75</td>
<td>120</td>
<td>209</td>
</tr>
<tr>
<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace;</td>
<td>22.09</td>
<td>0.078</td>
<td>479</td>
<td>75</td>
<td>150</td>
<td>254</td>
</tr>
</tbody>
</table>
Other Code Comparison

Codes 38720 and 44140 bracket and offer further support of the recommended wRVU of 22.09 for 22630.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTION</th>
<th>RVW</th>
<th>WP</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>38720</td>
<td>Cervical lymphadenectomy (complete)</td>
<td>21.95</td>
<td>0.075</td>
<td>482</td>
<td>75</td>
<td>150</td>
<td>257</td>
</tr>
<tr>
<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
<td>22.09</td>
<td>0.078</td>
<td>479</td>
<td>75</td>
<td>150</td>
<td>254</td>
</tr>
<tr>
<td>44140</td>
<td>Colectomy, partial; with anastomosis</td>
<td>22.59</td>
<td>0.079</td>
<td>480</td>
<td>60</td>
<td>150</td>
<td>270</td>
</tr>
</tbody>
</table>

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?
CPT Code: 22630

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>4100</td>
<td>72.51 %</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>1554</td>
<td>27.48 %</td>
</tr>
<tr>
<td>Specialties</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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:
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.
CPT Code: 22632

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
RUC Recommended RVU: 5.22

Global Period: ZZZ Current Work 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AANS, CNS, AAOS, NASS, ISASS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>22632</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2028</td>
</tr>
<tr>
<td>Resp N:</td>
<td>111</td>
</tr>
</tbody>
</table>

**Description of Sample:** random

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>1.00</td>
<td>5.00</td>
<td>20.00</td>
<td>300.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>3.00</td>
<td>6.23</td>
<td>7.48</td>
<td>9.44</td>
<td>34.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>22.00</td>
<td>45.00</td>
<td>60.00</td>
<td>60.00</td>
<td>240.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>22632</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>5.22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:**

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
CPT Code: 22632

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22614</td>
<td>ZZZ</td>
<td>6.43</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptors: 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22552</td>
<td>ZZZ</td>
<td>6.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptors: 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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

CPT Descriptors: 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, 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: 26 % of respondents: 23.4 %

Number of respondents who choose 2nd Key Reference Code: 23 % of respondents: 20.7 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 22632</th>
<th>Top Key Reference CPT Code: 22614</th>
<th>2nd Key Reference CPT Code: 22552</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>40.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>60.00</td>
<td>40.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES (of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
<td>50%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment
- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>31%</td>
<td>69%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

Technical skill required

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>
### Physical effort required

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Identical</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>More</td>
<td>62%</td>
<td></td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>4%</td>
<td>39%</td>
<td>57%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td></td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>9%</td>
<td>48%</td>
<td>43%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22632</td>
<td>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)</td>
<td>5.22</td>
<td>0.087</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>22614</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
<td>6.43</td>
<td>0.161</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>22552</td>
<td>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)</td>
<td>6.50</td>
<td>0.142</td>
<td>50</td>
<td>5</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary)</td>
<td>4.13</td>
<td>0.103</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
</tbody>
</table>
CPT Code: 22632

<table>
<thead>
<tr>
<th>CPT</th>
<th>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)</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22632</td>
<td></td>
<td>5.22</td>
<td>0.087</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 11008 and 22854 bracket and offer further support of the recommended wRVU of 5.22 for 22632.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>11008</td>
<td>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)</td>
<td>5.00</td>
<td>0.087</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>22632</td>
<td>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)</td>
<td>5.22</td>
<td>0.087</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>22854</td>
<td>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)</td>
<td>5.50</td>
<td>0.092</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>1300</td>
<td>69.33</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>575</td>
<td>30.66</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>1300</td>
<td>69.33</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>575</td>
<td>30.66</td>
</tr>
</tbody>
</table>

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:** 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.
CPT Code: 22633

SUMMARY OF RECOMMENDATION

CPT Code: 22633 Tracking Number J3 Original Specialty Recommended RVU: 26.80

Presented Recommended RVU: 26.80

RUC Recommended RVU: 26.80

Global Period: 090 Current Work RVU: 27.75

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 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AANS, CNS, AAOS, NASS, ISASS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>22633</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2028</td>
</tr>
<tr>
<td>Resp N:</td>
<td>111</td>
</tr>
</tbody>
</table>

### Description of Sample:
Random

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>22.00</td>
<td>40.00</td>
<td>75.00</td>
<td>200.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>19.00</td>
<td>28.00</td>
<td>30.00</td>
<td>32.00</td>
<td>48.24</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
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<tr>
<td>Pre-Service Positioning Time:</td>
<td>20.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td>150.00</td>
<td>180.00</td>
<td>210.00</td>
<td>300.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td><strong>30.00</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>100.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>38.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>86.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td><strong>0.00</strong></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Recommended Pre-Service Time</th>
<th>Specialties</th>
<th>Recommended Pre-Service Time</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40.00</td>
<td></td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>20.00</td>
<td></td>
<td>3.00</td>
<td>17.00</td>
</tr>
<tr>
<td></td>
<td>15.00</td>
<td></td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td></td>
<td>180.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specialties**

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Recommended Post-Service Time</th>
<th>Specialties</th>
<th>Recommended Post-Service Time</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30.00</td>
<td></td>
<td>33.00</td>
<td>-3.00</td>
</tr>
</tbody>
</table>

**Specialties**

**9B General Anes or Complex Regional Blk/Cmplx Proc**

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Recommended Post-Service Time</th>
<th>Specialties</th>
<th>Recommended Post-Service Time</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 22633

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>100.00</td>
<td>99231x 1.00 99232x 2.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>38.00</td>
<td>99238x 1.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>86.00</td>
<td>99211x 0.00 12x 0.00 13x 2.00 14x 1.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22612</td>
<td>090</td>
<td>23.53</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22857</td>
<td>090</td>
<td>27.13</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>55866</td>
<td>090</td>
<td>26.80</td>
<td>RUC Time</td>
<td>20,334</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>33641</td>
<td>090</td>
<td>29.58</td>
<td>RUC Time</td>
<td>1,849</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch

**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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 22633</th>
<th>Top Key Reference CPT Code: 22612</th>
<th>2nd Key Reference CPT Code: 22857</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>75.00</td>
<td>95.00</td>
<td>95.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>180.00</td>
<td>150.00</td>
<td>180.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>38.00</td>
<td>38.00</td>
<td>38.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>86.00</td>
<td>69.00</td>
<td>92.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>509.00</td>
<td>482.00</td>
<td>550.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>23%</td>
<td>41%</td>
<td>36%</td>
</tr>
</tbody>
</table>

#### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>5%</td>
<td>23%</td>
<td>73%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>23%</td>
<td>77%</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22612</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</td>
<td>23.53</td>
<td>0.088</td>
<td>482</td>
<td>95</td>
<td>150</td>
<td>237</td>
</tr>
<tr>
<td>22633</td>
<td>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</td>
<td>26.80</td>
<td>0.091</td>
<td>509</td>
<td>75</td>
<td>180</td>
<td>254</td>
</tr>
<tr>
<td>22857</td>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar</td>
<td>27.13</td>
<td>0.086</td>
<td>550</td>
<td>95</td>
<td>180</td>
<td>275</td>
</tr>
</tbody>
</table>

MPC Code Comparison

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed</td>
<td>26.80</td>
<td>0.104</td>
<td>442</td>
<td>68</td>
<td>180</td>
<td>194</td>
</tr>
<tr>
<td>22633</td>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including</td>
<td>26.80</td>
<td>0.091</td>
<td>509</td>
<td>75</td>
<td>180</td>
<td>254</td>
</tr>
</tbody>
</table>
CPT Code: 22633

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWP</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>33641</td>
<td>Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch</td>
<td>29.58</td>
<td>0.094</td>
<td>562</td>
<td>95</td>
<td>164</td>
<td>303</td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 43281 and 33255 bracket and offer further support of the recommended wRVU of 26.80 for 22633.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWP</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>43281</td>
<td>Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh</td>
<td>26.60</td>
<td>0.107</td>
<td>424</td>
<td>70</td>
<td>180</td>
<td>174</td>
</tr>
<tr>
<td>22633</td>
<td>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</td>
<td>26.80</td>
<td>0.091</td>
<td>509</td>
<td>75</td>
<td>180</td>
<td>254</td>
</tr>
<tr>
<td>33255</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass</td>
<td>29.04</td>
<td>0.106</td>
<td>516</td>
<td>95</td>
<td>180</td>
<td>241</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
<td>%</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
<td>%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>neurosurgery</td>
<td>19800</td>
<td>51.97</td>
<td></td>
</tr>
<tr>
<td>orthopaedic surgery</td>
<td>18286</td>
<td>47.99</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

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:
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.
CPT Code: 22634

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 22634    Tracking Number: J4    Original Specialty Recommended RVU: 7.96

Global Period: ZZZ    Current Work RVU: 8.16    Presented 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AANS, CNS, AAOS, NASS, ISASS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>22634</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2028</td>
</tr>
<tr>
<td>Resp N:</td>
<td>111</td>
</tr>
</tbody>
</table>

#### Description of Sample:
- Random

#### Table:

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25\textsuperscript{th} pctl</th>
<th>Median\textsuperscript{*}</th>
<th>75\textsuperscript{th} pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>10.00</td>
<td>25.00</td>
<td>43.00</td>
<td>200.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>3.50</td>
<td>7.96</td>
<td>8.83</td>
<td>10.00</td>
<td>36.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>24.00</td>
<td>48.00</td>
<td>65.00</td>
<td>80.00</td>
<td>220.00</td>
</tr>
</tbody>
</table>

#### Immediate Post Service-Time:
- 0.00

#### Post Operative Visits

<table>
<thead>
<tr>
<th>CPT Code (and Number of Visits)</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>CPT Code: 22634</th>
<th>Recommended Physician Work RVU: 7.96</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>0.00 0.00 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00 0.00 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00 0.00 0.00</td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>65.00</td>
</tr>
</tbody>
</table>

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)

| Immediate Post Service-Time: | 0.00 0.00 0.00 |
CPT Code: 22634

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22614</td>
<td>ZZZ</td>
<td>6.43</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22840</td>
<td>ZZZ</td>
<td>12.52</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 22634</th>
<th>Top Key Reference CPT Code: 22614</th>
<th>2nd Key Reference CPT Code: 22840</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>65.00</td>
<td>40.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>65.00</td>
<td>40.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>12%</td>
<td>40%</td>
<td>44%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4%</td>
<td>20%</td>
<td>76%</td>
</tr>
</tbody>
</table>
Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>24%</td>
<td>72%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>4%</td>
<td>16%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4%</td>
<td>32%</td>
<td>64%</td>
</tr>
</tbody>
</table>

- 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

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>9%</td>
<td>22%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4%</td>
<td>13%</td>
<td>83%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>17%</td>
<td>78%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>9%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9%</td>
<td>4%</td>
<td>87%</td>
</tr>
</tbody>
</table>

- 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

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, laminctomy, 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22614</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
<td>6.43</td>
<td>0.161</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>22634</td>
<td>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)</td>
<td>7.96</td>
<td>0.122</td>
<td>65</td>
<td>0</td>
<td>65</td>
<td>0</td>
</tr>
<tr>
<td>22840</td>
<td>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)</td>
<td>12.52</td>
<td>0.209</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUR</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)</td>
<td>4.13</td>
<td>0.103</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>22634</td>
<td>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)</td>
<td>7.96</td>
<td>0.122</td>
<td>65</td>
<td>0</td>
<td>65</td>
<td>0</td>
</tr>
</tbody>
</table>

**Other Code Comparison**

The codes below bracket and offer further support of the recommended wRVU of 7.96 for 22634.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUR</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34820</td>
<td>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)</td>
<td>7.00</td>
<td>0.117</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>22634</td>
<td>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)</td>
<td>7.96</td>
<td>0.122</td>
<td>65</td>
<td>0</td>
<td>65</td>
<td>0</td>
</tr>
<tr>
<td>33746</td>
<td>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/Sennin/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)</td>
<td>8.00</td>
<td>0.133</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>93592</td>
<td>Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)</td>
<td>8.00</td>
<td>0.133</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>33884</td>
<td>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)</td>
<td>8.20</td>
<td>0.137</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>

**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.
CPT Code: 22634

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty neurosurgery</td>
<td>7900</td>
<td>55.09 %</td>
</tr>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>6438</td>
<td>44.90 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty neurosurgery</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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:
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.
CPT Code: 63052

Tracking Number: J5

Original Specialty Recommended RVU: 5.70

Presented Recommended RVU: 5.70

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>63052</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RUC Meeting Date (mm/yyyy)</strong></td>
<td>04/2021</td>
</tr>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>AANS, CNS, AAOS, NASS, ISASS</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>63052</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>2028</td>
</tr>
<tr>
<td><strong>Resp N:</strong></td>
<td>111</td>
</tr>
<tr>
<td><strong>Description of Sample:</strong></td>
<td>random</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>29.00</td>
<td>50.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>3.20</td>
<td>5.70</td>
<td>6.50</td>
<td>9.83</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>15.00</td>
<td>30.00</td>
<td>45.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Post Operative Visits

- **Critical Care time/visit(s):** 0.00
- **Other Hospital time/visit(s):** 0.00
- **Discharge Day Mgmt:** 0.00
- **Office time/visit(s):** 0.00
- **Prolonged Services:** 0.00
- **Sub Obs Care:** 0.00

---

**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)

**Specialty Society Recommended Data**

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)

---

**CPT Code:** 63052  
**Recommended Physician Work RVU:** 5.70

### CPT Code: 63052

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>45.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

**Physician standard total minutes per E/M visit:**
- 99291 (70)
- 99292 (30)
- 99231 (20)
- 99232 (40)
- 99233 (55)
- 99238 (38)
- 99239 (55)
- 99211 (7)
- 99212 (16)
- 99213 (23)
- 99214 (40)
- 99215 (55)
- 99224 (20)
- 99225 (40)
- 99226 (55)
- 99354 (60)
- 99355 (30)
- 99356 (60)
- 99357 (30)
CPT Code: 63052

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22840</td>
<td>ZZZ</td>
<td>12.52</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Posterior non-segmental instrumentation (e.g., 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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22208</td>
<td>ZZZ</td>
<td>9.66</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., 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.

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

CPT Descriptor: Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

CPT Descriptor
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)

<table>
<thead>
<tr>
<th>Time Estimate</th>
<th>CPT Code: 63052</th>
<th>Top Key Reference CPT Code: 22840</th>
<th>2nd Key Reference CPT Code: 22208</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>22840.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>60.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>45.00</td>
<td>60.00</td>
<td>135.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES
*(of those that selected Key Reference codes)*

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
<td>33%</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>26%</td>
<td>70%</td>
</tr>
</tbody>
</table>
CPT Code: 63052

Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>26%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>22%</td>
<td>74%</td>
</tr>
</tbody>
</table>

- 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

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>33%</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>39%</td>
<td>11%</td>
<td>50%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>22%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>17%</td>
<td>50%</td>
</tr>
</tbody>
</table>

- 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

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IINPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22840</td>
<td>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)</td>
<td>12.52</td>
<td>0.209</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>63052</td>
<td>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)</td>
<td>5.70</td>
<td>0.127</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>22208</td>
<td>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)</td>
<td>9.66</td>
<td>0.78</td>
<td>135</td>
<td>0</td>
<td>120</td>
<td>15</td>
</tr>
</tbody>
</table>

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 Code: 63052

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)</td>
<td>4.13</td>
<td>0.103</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>63052</td>
<td>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)</td>
<td>5.70</td>
<td>0.127</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 22585 and 22552 bracket and offer further support of the recommended wRVU of 5.70 for 63052.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22585</td>
<td>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)</td>
<td>5.52</td>
<td>0.123</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>63052</td>
<td>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)</td>
<td>5.70</td>
<td>0.127</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>22552</td>
<td>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)</td>
<td>6.50</td>
<td>0.142</td>
<td>50</td>
<td>5</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty neurosurgery</td>
<td>Frequency 5830</td>
<td>Percentage 53.00 %</td>
<td></td>
</tr>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>Frequency 5170</td>
<td>Percentage 47.00 %</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency 0</td>
<td>Percentage 0.00 %</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty neurosurgery</th>
<th>Frequency 5830</th>
<th>Percentage 53.00 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>Frequency 5170</td>
<td>Percentage 47.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency 0</td>
<td>Percentage 0.00 %</td>
</tr>
</tbody>
</table>

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:
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
CPT Code: 63053

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 Global 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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>15.00</td>
<td>30.00</td>
<td>70.00</td>
<td>400.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>3.00</td>
<td>5.00</td>
<td>6.00</td>
<td>7.38</td>
<td>25.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>15.00</td>
<td>30.00</td>
<td>40.00</td>
<td>45.00</td>
<td>210.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 0.00

**Post Operative 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)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Recommended Pre-Service Time</th>
<th>Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>40.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Recommended Post-Service Time</th>
<th>Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.0 99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22614</td>
<td>ZZZ</td>
<td>6.43</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22840</td>
<td>ZZZ</td>
<td>12.52</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>RUC Time</td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor: 2

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 63053</th>
<th>Top Key Reference CPT Code: 22614</th>
<th>2nd Key Reference CPT Code: 22840</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>40.00</td>
<td>40.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>40.00</td>
<td>40.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>21%</td>
<td>63%</td>
<td>16%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>32%</td>
<td>68%</td>
</tr>
</tbody>
</table>

- 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
Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>5%</td>
<td>16%</td>
<td>79%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
<td>32%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22614</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
<td>6.43</td>
<td>0.161</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>63053</td>
<td>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)</td>
<td>5.00</td>
<td>0.125</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>22840</td>
<td>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)</td>
<td>12.52</td>
<td>0.209</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)</td>
<td>4.13</td>
<td>0.103</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>63053</td>
<td>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)</td>
<td>5.00</td>
<td>0.125</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 44128 and 22585 bracket and offer further support of the recommended wRVU of 5.00 for 63053.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>44128</td>
<td>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)</td>
<td>4.44</td>
<td>0.106</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>63053</td>
<td>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)</td>
<td>5.00</td>
<td>0.125</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>22585</td>
<td>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)</td>
<td>5.52</td>
<td>0.123</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

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
CPT Code: 63053

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty neurosurgery</td>
<td>Frequency 2120</td>
<td>Percentage 53.00 %</td>
</tr>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>Frequency 1880</td>
<td>Percentage 47.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty neurosurgery</th>
<th>Frequency 2120</th>
<th>Percentage 53.00 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>Frequency 1880</td>
<td>Percentage 47.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency 0</td>
<td>Percentage 0.00 %</td>
</tr>
</tbody>
</table>

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:
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.
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 discectomy 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 discectomy 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

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<th>MED</th>
<th>75th MAX</th>
<th>Total</th>
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<th>INTRA</th>
<th>IMMD</th>
<th>POST Facility</th>
<th>POST-Office</th>
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**MPC** 55866 Laparoscopy, surgical prostatectomy, retroperitoneal

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<th>IMMD</th>
<th>POST Facility</th>
<th>POST-Office</th>
<th>12 Month SVY Experience</th>
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</thead>
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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

<table>
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<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
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<tbody>
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<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
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</tr>
<tr>
<td>22632</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
<tr>
<td>22633</td>
<td>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</td>
<td>090</td>
</tr>
<tr>
<td>22634</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
<tr>
<td>63052</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
<tr>
<td>63053</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>22630</td>
<td>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.)</td>
</tr>
<tr>
<td>22633</td>
<td>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.)</td>
</tr>
<tr>
<td>22632</td>
<td>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</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>22634</td>
<td>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 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 arthrodesis of the additional L5-S1 interspace.)</td>
</tr>
<tr>
<td>63052</td>
<td>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].)</td>
</tr>
<tr>
<td>63053</td>
<td>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.)</td>
</tr>
</tbody>
</table>

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
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)

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
      Coordinator pre-service diagnostic and referral forms
      Coordinate pre-surgery services (including test results)
      Schedule space and equipment in facility
      Provide pre-service education/obtain consent
      Complete pre-procedure phone calls and prescription
      Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
      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.
      Staff interacts with facility to schedule space, supplies, equipment, and review checklists.
      Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
      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.

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<tr>
<td>cover, thermometer probe</td>
<td></td>
<td>item</td>
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<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Code</th>
<th>Unit</th>
<th>Item</th>
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</table>

4
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)

<table>
<thead>
<tr>
<th>pack, post-op incision care (suture &amp; staple)</th>
<th>Qty</th>
<th>price</th>
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</thead>
<tbody>
<tr>
<td>kit, staple removal</td>
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<tr>
<td>kit, suture removal</td>
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<tr>
<td>povidone soln (Betadine)</td>
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<tr>
<td>gauze, sterile 4in x 4in</td>
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<td>gloves, sterile</td>
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<td>steri-strip (6 strip uou)</td>
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<tr>
<td>swab-pad, alcohol</td>
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<tr>
<td>tape, surgical paper 1in (Micropore)</td>
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<tr>
<td>tincture of benzoin, swab</td>
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</tbody>
</table>

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
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.
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<thead>
<tr>
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<td>TOTAL CLINICAL STAFF TIME</td>
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<tr>
<td>TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE</td>
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</tbody>
</table>

### Pre-SERVICE Period
- Start: Following visit when decision for surgery/procedure made
- End: When patient enters office/facility for surgery/procedure

### Service Period
- Start: When patient enters office/facility for surgery/procedure
- End: Patient leaves office/facility

### Post-SERVICE Period
- Start: Patient leaves office/facility

### Office visits: List Number and Level of Office Visits

| MINUTES | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits | # visits |
|---------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| L037D   | 0.0      | 144.0    | 125.0    | 108.0    | 125.0    | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      |

### Pre-Recomendation
- Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (th th f)
- Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression)

### Current recommend
- Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (th th f)
- Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression)

### Current Recommended
- Arthrodesis, combined posterior or posterolateral technique with posterior interbody (th i l d)
- Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression)
A
B
1 RUC Practice Expense Spreadsheet
2
3
RUC Collaboration Website
Meeting Date: 04/2021
Clinical
Revision Date (if applicable): April 7, 2021
Activity Code Tab: 4
4
Specialty: AANS, CNS, AAOS, NASS, ISASS
LOCATION
5
6
GLOBAL PERIOD
TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND
7
EQUIPMENT TIME
8
TOTAL CLINICAL STAFF TIME
TOTAL PRE-SERVICE CLINICAL STAFF TIME
9
TOTAL SERVICE PERIOD CLINICAL STAFF TIME
10
11
TOTAL POST-SERVICE CLINICAL STAFF TIME
96 Supply Code MEDICAL SUPPLIES
97
TOTAL COST OF SUPPLY QUANTITY x PRICE
98
SA048
99
SA052
100
SA053
101
103
104
105
106
107

Equipment
Code
EF031
EF014
EQ168

EQUIPMENT
TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE

D

E

Clinical
Staff Type
Code

Clinical
Staff Type

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I
J
CURRENT
22630
Arthrodesis, posterior
interbody technique,
Clinical Staff including laminectomy
Type Rate
and/or discectomy to
Per Minute
prepare interspace
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Office Visits
Office Visits

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Cost Per
Minute

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CURRENT
RECOMMENDED
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22633
22633
Arthrodesis, posterior Arthrodesis, combined Arthrodesis, combined
interbody technique,
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posterior or
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and/or discectomy to
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RECOMMENDED
RECOMMENDED
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22632
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Arthrodesis, posterior Arthrodesis, combined
Laminectomy,
interbody technique,
posterior or
facetectomy, or
including laminectomy
posterolateral
foraminotomy
and/or discectomy to
technique with
(unilateral or bilateral
prepare interspace
posterior interbody
with decompression
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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; transformamal 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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU</th>
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</thead>
<tbody>
<tr>
<td>31575</td>
<td>5</td>
<td>Laryngoscopy, flexible; diagnostic</td>
<td>000</td>
<td>1.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 31575 in conjunction with 31231, unless performed for a separate condition using a separate endoscope)</td>
<td></td>
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<tr>
<td></td>
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<td>(Do not report 31575 in conjunction with 31572, 31573, 31574, 31576, 31577, 31578, 42975, 43197, 43198, 92511, 92612, 92614, 92616)</td>
<td></td>
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<tr>
<td>●42975</td>
<td>M1</td>
<td>Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic</td>
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<td>(Do not report 42975 in conjunction with 31575, 92511)</td>
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<tr>
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<td>(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)</td>
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<tr>
<td>92511</td>
<td></td>
<td>Nasopharyngoscopy with endoscope (separate procedure)</td>
<td>000</td>
<td>1.95</td>
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<td>(Do not report 92511 in conjunction with 31575, 42975, 43197, 43198)</td>
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<td>(For nasopharyngoscopy, surgical, with dilation of eustachian tube, see 69705, 69706)</td>
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</tbody>
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CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
CPT Code: 42975

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 42975  Tracking Number  Original Specialty Recommended RVU: 1.95
Global Period: 000  Current Work RVU:  Presented Recommended RVU: 1.95
RUC Recommended RVU: 1.95

CPT Descriptor: Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and larynx 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**

<table>
<thead>
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<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
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<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
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<table>
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| Description of Sample:     | Targeted Random Sample |

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| Survey RVW:                | 1.00 | 1.95      | 2.30    | 2.75      | 44.00 |

<table>
<thead>
<tr>
<th>Pre-Service Evaluation Time:</th>
<th>19.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>5.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>7.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>2.00</td>
</tr>
</tbody>
</table>

| Immediate Post Service-Time: | 10.00 |

<table>
<thead>
<tr>
<th>Post Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00</td>
</tr>
<tr>
<td>Other hospital/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00</td>
</tr>
<tr>
<td>Discharge day mgmt:</td>
<td>0.00</td>
<td>99238x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00</td>
</tr>
<tr>
<td>Prolonged services:</td>
<td>0.00</td>
<td>99354x 0.00</td>
</tr>
<tr>
<td>Sub obs care:</td>
<td>0.00</td>
<td>99224x 0.00</td>
</tr>
</tbody>
</table>

**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)

| Pre-Service Evaluation Time: | 18.00 |
| Pre-Service Positioning Time: | 1.00 |
| Pre-Service Scrub, Dress, Wait Time: | 6.00 |
| Intra-Service Time: | 15.00 |

**Recommended Physician Work RVU: 1.95**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>42975</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Recommended Pre-Service Time</td>
<td>18.00</td>
</tr>
<tr>
<td>Specialty Recommended Pre-Time Package</td>
<td>18.00</td>
</tr>
<tr>
<td>Adjustments/Recommended Pre-Service Time</td>
<td>0.00</td>
</tr>
</tbody>
</table>

| Pre-Service Evaluation Time: | 18.00 |
| Pre-Service Positioning Time: | 1.00 |
| Pre-Service Scrub, Dress, Wait Time: | 6.00 |
| 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)

<table>
<thead>
<tr>
<th>8B IV Sedation/Complex Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Recommended Post-Service Time</td>
</tr>
<tr>
<td>Specialty Recommended Post-Time Package</td>
</tr>
<tr>
<td>Adjustments/Recommended Post-Service Time</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
</tr>
<tr>
<td>Prolonged Services:</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>000</td>
<td>1.88</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Laryngoscopy, flexible or rigid telescopic, with stroboscopy

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31575</td>
<td>000</td>
<td>0.94</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>54150</td>
<td>000</td>
<td>1.90</td>
<td>RUC Time</td>
<td>250</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Circumcision, using clamp or other device with regional dorsal penile or ring block

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>64483</td>
<td>000</td>
<td>1.90</td>
<td>RUC Time</td>
<td>1,044,547</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

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)
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 42975</th>
<th>Top Key Reference CPT Code: 31579</th>
<th>2nd Key Reference CPT Code: 31575</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>25.00</td>
<td>14.00</td>
<td>14.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>15.00</td>
<td>10.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>10.00</td>
<td>10.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>50.00</td>
<td>34.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>57%</td>
<td>23%</td>
</tr>
</tbody>
</table>

#### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>20%</td>
<td>77%</td>
</tr>
</tbody>
</table>

#### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>63%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Physical effort required

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td>55%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td>45%</td>
<td>55%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>5%</td>
<td>25%</td>
<td>58%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>8%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>17%</td>
<td>75%</td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>IWPUMedicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>62320</td>
<td>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</td>
<td>000</td>
<td>1.80</td>
<td>15</td>
<td>43</td>
<td>2015-10</td>
<td>0.083</td>
</tr>
<tr>
<td>62323</td>
<td>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)</td>
<td>000</td>
<td>1.80</td>
<td>15</td>
<td>45</td>
<td>2015-10</td>
<td>0.08</td>
</tr>
<tr>
<td>15275</td>
<td>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</td>
<td>000</td>
<td>1.83</td>
<td>15</td>
<td>45</td>
<td>2011-04</td>
<td>0.0829</td>
</tr>
<tr>
<td>47537</td>
<td>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</td>
<td>000</td>
<td>1.84</td>
<td>15</td>
<td>52</td>
<td>2015-10</td>
<td>0.0731</td>
</tr>
<tr>
<td>62324</td>
<td>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</td>
<td>000</td>
<td>1.89</td>
<td>15</td>
<td>43</td>
<td>2015-10</td>
<td>0.089</td>
</tr>
<tr>
<td>62327</td>
<td>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)</td>
<td>000</td>
<td>1.90</td>
<td>15</td>
<td>45</td>
<td>2015-10</td>
<td>0.0866</td>
</tr>
<tr>
<td>11983</td>
<td>Removal with reinsertion, non-biodegradable drug delivery implant</td>
<td>000</td>
<td>1.91</td>
<td>15</td>
<td>40</td>
<td>2018-10</td>
<td>0.0938</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Unit</td>
<td>Value</td>
<td>Modifier</td>
<td>Date</td>
<td>Value</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>-------</td>
<td>----------</td>
<td>----------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>36555</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age</td>
<td>000</td>
<td>1.93</td>
<td>15</td>
<td>48</td>
<td>2016-10</td>
<td>0.0842</td>
</tr>
<tr>
<td>62321</td>
<td>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)</td>
<td>000</td>
<td>1.95</td>
<td>15</td>
<td>45</td>
<td>2015-10</td>
<td>0.09</td>
</tr>
<tr>
<td>92960</td>
<td>Cardioversion, elective, electrical conversion of arrhythmia; external</td>
<td>000</td>
<td>2.00</td>
<td>15</td>
<td>46</td>
<td>2010-10</td>
<td>0.0918</td>
</tr>
<tr>
<td>45338</td>
<td>Sigmoidoscopy, flexible; with removal of tumor(s), polypp(s), or other lesion(s) by snare technique</td>
<td>000</td>
<td>2.05</td>
<td>15</td>
<td>48</td>
<td>2013-10</td>
<td>0.0922</td>
</tr>
<tr>
<td>69801</td>
<td>Labyrinthotomy, with perfusion of vestibulovactive drug(s), transcanal</td>
<td>000</td>
<td>2.06</td>
<td>15</td>
<td>43</td>
<td>2010-04</td>
<td>0.1003</td>
</tr>
<tr>
<td>43235</td>
<td>Esophagastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>000</td>
<td>2.09</td>
<td>15</td>
<td>49</td>
<td>2013-01</td>
<td>0.0933</td>
</tr>
<tr>
<td>31577</td>
<td>Laryngoscopy, flexible; with removal of foreign body(s)</td>
<td>000</td>
<td>2.19</td>
<td>15</td>
<td>48</td>
<td>2015-10</td>
<td>0.1053</td>
</tr>
<tr>
<td>62325</td>
<td>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)</td>
<td>000</td>
<td>2.20</td>
<td>15</td>
<td>45</td>
<td>2015-10</td>
<td>0.1066</td>
</tr>
<tr>
<td>31573</td>
<td>Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral</td>
<td>000</td>
<td>2.43</td>
<td>15</td>
<td>52</td>
<td>2015-10</td>
<td>0.1153</td>
</tr>
<tr>
<td>31574</td>
<td>Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral</td>
<td>000</td>
<td>2.43</td>
<td>15</td>
<td>55</td>
<td>2015-10</td>
<td>0.1108</td>
</tr>
<tr>
<td>31578</td>
<td>Laryngoscopy, flexible; with removal of lesion(s), non-laser</td>
<td>000</td>
<td>2.43</td>
<td>15</td>
<td>51</td>
<td>2015-10</td>
<td>0.1168</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
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<tbody>
<tr>
<td>Otolaryngology</td>
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</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
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<tr>
<td>Specialty</td>
<td>How often?</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Otolaryngology</td>
<td>106858</td>
<td>100.00 %</td>
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<tr>
<td>Specialty</td>
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<td>0.00 %</td>
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</tbody>
</table>

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.

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<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
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<tr>
<td>Specialty</td>
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<td>0.00 %</td>
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</tbody>
</table>

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:
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

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
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<th>DESC</th>
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<th>Total</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMDD</th>
<th>FAC-inpt/same day</th>
<th>SURVEY EXPERIENCE</th>
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<td>1st REF</td>
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**Work Per Unit Time:**
- MIN 25th MED 75th MAX
- PRE-TIME
- INTRA-TIME
- IMMDD
- FAC-inpt/same day
- SURVEY EXPERIENCE
Meeting Date: April 2021

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<th>CPT Code</th>
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Vignette(s) (vignette required even if PE only code(s)):

<table>
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<tr>
<th>CPT Code</th>
<th>Vignette</th>
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<td>42975</td>
<td>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</td>
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</tbody>
</table>

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.
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.
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 Latitude 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).
N/A new code.
### Meeting Date: April 2021
Revision Date (if applicable):
Tab: 5
Specialty: AAO-HNS

#### Clinical Activity Code

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Non Fac</th>
<th>Facility</th>
<th>Non Fac</th>
<th>Facility</th>
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<tbody>
<tr>
<td>GLOBAL PERIOD</td>
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<tr>
<td>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</td>
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<tr>
<td>Start: Following visit when decision for surgery/procedure made</td>
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<td>Other activity: please include short clinical description here and type new in</td>
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<tr>
<td>End: When patient enters office/facility for surgery/procedure</td>
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<td>SERVICE PERIOD</td>
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<td>Pre-Service (of service period)</td>
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<td>Start: Patient leaves office/facility</td>
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<td>End: with last office visit before end of global period</td>
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**REFERENCE CODE**

CPT Code 31576

Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic

**RECOMMENDED**

CPT Code 42975

Laryngoscopy, flexible; with biopsies (
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<th>B</th>
<th>C</th>
<th>D</th>
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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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
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<tbody>
<tr>
<td>Auditory System</td>
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<tr>
<td>Middle Ear</td>
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<tr>
<td>Osseointegrated Implants</td>
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</table>

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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>MFS 2022</th>
<th>Reference</th>
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<tbody>
<tr>
<td>▲69714</td>
<td>U1</td>
<td>Implantation, osseointegrated implant, temporal bone, skull; with percutaneous attachment to external speech processor/cochlear stimulator, without mastoidectomy</td>
<td>8.69</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 8.69)</td>
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<tr>
<td>●69716</td>
<td>U2</td>
<td>with magnetic transcutaneous attachment to external speech processor</td>
<td>9.77</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 9.77)</td>
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<tr>
<td>69715</td>
<td>-</td>
<td>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)</td>
<td>N/A</td>
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<tr>
<td>▲69717</td>
<td>U3</td>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, temporal bone, skull; with percutaneous attachment to external speech processor/cochlear stimulator, without mastoidectomy</td>
<td>8.80</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 8.80)</td>
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<tr>
<td>●69719</td>
<td>U4</td>
<td>with magnetic transcutaneous attachment to external speech processor</td>
<td>9.77</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 9.77)</td>
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<tr>
<td>69718</td>
<td>-</td>
<td>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)</td>
<td>090</td>
<td>N/A</td>
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<tr>
<td>●69726</td>
<td>U5</td>
<td>Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor</td>
<td>090</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 5.93)</td>
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<tr>
<td>●69727</td>
<td>U6</td>
<td>with magnetic transcution attachment to external speech processor</td>
<td>090</td>
<td>Refer to CPT May 2021/Survey October 2021 (Interim January 2021 RUC Recommendation affirmed for 2022 MFS = 7.13)</td>
</tr>
</tbody>
</table>
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
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.
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
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 CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.*
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
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 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.
**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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>69714</td>
<td>U1</td>
<td>Implantation, osseointegrated implant, temporal bone skull, with percutaneous attachment to external speech processor/cochlear stimulator, without mastoidectomy</td>
<td>090</td>
<td>8.69 (Interim) (Resurvey for April 2021)</td>
</tr>
<tr>
<td>69716</td>
<td>U2</td>
<td>with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
<td>9.77 (Interim) (Resurvey for April 2021)</td>
</tr>
<tr>
<td>69715</td>
<td>-</td>
<td>with mastoidectomy</td>
<td>090</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th></th>
<th>(69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)</th>
</tr>
</thead>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Value</th>
<th>Interim Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69717</td>
<td>U3</td>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, temporal bone, skull; with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy</td>
<td>090</td>
<td>8.80</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Interim)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Resurvey for April 2021)</td>
</tr>
<tr>
<td>69719</td>
<td>U4</td>
<td>with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
<td>9.77</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Interim)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Resurvey for April 2021)</td>
</tr>
<tr>
<td>69718</td>
<td>-</td>
<td>with mastoidectomy</td>
<td>090</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69726</td>
<td>U5</td>
<td>Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor</td>
<td>090</td>
<td>5.93</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Interim)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Resurvey for April 2021)</td>
</tr>
<tr>
<td>69727</td>
<td>U6</td>
<td>with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
<td>7.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Interim)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Resurvey for April 2021)</td>
</tr>
</tbody>
</table>
CPT Code: 69714 Tracking Number

Original Specialty Recommended RVU: 11.00
Presented Recommended RVU: 8.69
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 unable 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>69714</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>533</td>
</tr>
<tr>
<td>Resp N:</td>
<td>73</td>
</tr>
</tbody>
</table>

**Description of Sample:** Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

### Service Performance Rate

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25\textsuperscript{th} pctl</th>
<th>Median*</th>
<th>75\textsuperscript{th} pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>0.00</td>
<td>3.00</td>
<td>8.00</td>
<td>12.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>1.00</td>
<td>11.00</td>
<td>12.00</td>
<td>14.00</td>
<td>17.40</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>10.00</td>
<td>25.00</td>
<td>40.00</td>
<td>46.00</td>
<td>155.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 15.00

**Post Operative Visits Total Min**

| Critical Care time/visit(s): | 0.00 |
| Other Hospital time/visit(s): | 0.00 |
| Discharge Day Mgmt: | 62.00 |
| Office time/visit(s): | 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 |

**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 |

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>33.00</td>
<td>33.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>3.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
<td>15.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>40.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>15.00</td>
<td>30.00</td>
<td>-15.00</td>
</tr>
</tbody>
</table>
CPT Code: 69714

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>62.00</td>
<td>99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15120</td>
<td>090</td>
<td>10.15</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31610</td>
<td>090</td>
<td>12.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>67904</td>
<td>090</td>
<td>7.97</td>
<td>RUC Time</td>
<td>54,853</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>26615</td>
<td>090</td>
<td>7.07</td>
<td>RUC Time</td>
<td>1,057,533</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>66183</td>
<td>090</td>
<td>13.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>CPT Code: 69714</th>
<th>Top Key Reference CPT Code: 15120</th>
<th>2nd Key Reference CPT Code: 31610</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>46.00</td>
<td>72.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>40.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>62.0</td>
<td>62.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
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<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
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<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>182.00</td>
<td>258.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>14%</td>
<td>36%</td>
<td>36%</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>29%</td>
<td>50%</td>
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</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>21%</td>
<td>36%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>29%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant</td>
<td>24%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>complications, morbidity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>skill and judgment of</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>physician</td>
<td></td>
<td></td>
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<tr>
<td>Estimated risk of</td>
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<td>malpractice suit with</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>poor outcome</td>
<td></td>
<td></td>
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</tbody>
</table>

2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td>0%</td>
<td>21%</td>
<td>50%</td>
<td>14%</td>
<td>14%</td>
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</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
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<tbody>
<tr>
<td>The number of possible</td>
<td>14%</td>
<td>64%</td>
<td>21%</td>
</tr>
<tr>
<td>diagnosis and/or the</td>
<td></td>
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</tr>
<tr>
<td>number of management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>options that must be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>considered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount and/or the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>complexity of medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>records, diagnostic tests,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/or other information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>that must be reviewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>21%</td>
<td>36%</td>
<td>43%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>31%</td>
<td>54%</td>
<td>16%</td>
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</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant</td>
<td>42%</td>
<td>50%</td>
<td>8%</td>
</tr>
<tr>
<td>complications, morbidity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>skill and judgment of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>malpractice suit with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>WPUT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>46707</td>
<td>Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])</td>
<td>090</td>
<td>0.06</td>
<td>6.39</td>
<td>40</td>
<td>187</td>
<td>2009-04</td>
<td>COLORECTAL SURGERY (PROCTOLOGY)</td>
<td>39</td>
</tr>
<tr>
<td>59870</td>
<td>Uterine evacuation and curettage for hydatidiform mole</td>
<td>090</td>
<td>0.0084</td>
<td>6.57</td>
<td>40</td>
<td>256</td>
<td>2000-08</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>4</td>
</tr>
<tr>
<td>24358</td>
<td>Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open</td>
<td>090</td>
<td>0.0669</td>
<td>6.66</td>
<td>40</td>
<td>193</td>
<td>2007-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>664</td>
</tr>
<tr>
<td>25109</td>
<td>Excision of tendon, forearm and/or wrist, flexor or extensor, each</td>
<td>090</td>
<td>0.0632</td>
<td>6.94</td>
<td>40</td>
<td>191</td>
<td>2006-04</td>
<td>HAND SURGERY</td>
<td>268</td>
</tr>
<tr>
<td>26715</td>
<td>Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0461</td>
<td>7.03</td>
<td>40</td>
<td>220</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>216</td>
</tr>
<tr>
<td>29881</td>
<td>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</td>
<td>090</td>
<td>0.0637</td>
<td>7.03</td>
<td>40</td>
<td>194</td>
<td>2011-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>51597</td>
</tr>
<tr>
<td>52400</td>
<td>Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive</td>
<td>090</td>
<td>0.126</td>
<td>8.69</td>
<td>40</td>
<td>197.5</td>
<td>2008-04</td>
<td>UROLOGY</td>
<td>115</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otoloaryngology</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otoloaryngology</td>
<td>279</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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

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.
CPT Code: 69716

Tracking Number

Original Specialty Recommended RVU: 12.00
Presented Recommended RVU: 9.77
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 hearing 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 subperiosteal dissection is performed and a subperiosteal 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>69716</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Sample Size:</th>
<th>533</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resp N:</td>
<td>67</td>
</tr>
</tbody>
</table>

**Description of Sample:** Targeted, random survey of 533 otolaryngologist members of the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society)

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>2.00</td>
<td>4.00</td>
<td>10.00</td>
<td>30.00</td>
</tr>
</tbody>
</table>

| 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**

| 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 |

**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 |

| 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

| Immediate Post Service-Time: | 15.00 | 30.00 | -15.00 |
CPT Code: 69716

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office/visit(s):</td>
<td>46.00</td>
<td>99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31610</td>
<td>090</td>
<td>12.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Tracheostomy, fenestration procedure with skin flaps

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15730</td>
<td>090</td>
<td>13.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>57288</td>
<td>090</td>
<td>12.13</td>
<td>RUC Time</td>
<td>25,452</td>
</tr>
</tbody>
</table>

CPT Descriptor: Sling operation for stress incontinence (eg, fascia or synthetic)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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</thead>
<tbody>
<tr>
<td>54437</td>
<td>090</td>
<td>11.50</td>
<td>RUC Time</td>
<td>54</td>
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</tbody>
</table>

CPT Descriptor: Repair of traumatic corporeal tear(s)

Other Reference CPT Code | Global | Work RVU | Time Source |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27279</td>
<td>090</td>
<td>12.13</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 69716</th>
<th>Top Key Reference CPT Code: 31610</th>
<th>2nd Key Reference CPT Code: 15730</th>
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</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>45.00</td>
<td>6960.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>45.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>20.00</td>
<td>17.50</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>173.00</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.0</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Median Office Visit Time</td>
<td>46.0</td>
<td>69.00</td>
<td>71.00</td>
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<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>185.00</td>
<td>367.00</td>
<td>255.50</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>8%</td>
<td>0%</td>
<td>58%</td>
<td>17%</td>
<td>17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8%</td>
<td>58%</td>
<td>34%</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>8%</td>
<td>42%</td>
<td>50%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>75%</td>
<td>25%</td>
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</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>42%</td>
<td>33%</td>
<td>25%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
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</table>

### 2nd Key Reference Code

<table>
<thead>
<tr>
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<th>Much</th>
<th>Somewhat</th>
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<th>Much</th>
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<tr>
<td>Less</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More</td>
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<tr>
<td>More</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Overall intensity/complexity**

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>0%</th>
<th>33%</th>
<th>33%</th>
<th>33%</th>
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</thead>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
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<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
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<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
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<td></td>
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</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>IWPUT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>25607</td>
<td>Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation</td>
<td>090</td>
<td>0.0523</td>
<td>9.56</td>
<td>60</td>
<td>275</td>
<td>2006-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>9419</td>
</tr>
<tr>
<td>26356</td>
<td>Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon</td>
<td>090</td>
<td>0.0551</td>
<td>9.56</td>
<td>60</td>
<td>277</td>
<td>2015-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>1150</td>
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<tr>
<td>66184</td>
<td>Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft</td>
<td>090</td>
<td>0.0485</td>
<td>9.58</td>
<td>60</td>
<td>254</td>
<td>2014-01</td>
<td>OPHTHALMOLOGY</td>
<td>594</td>
</tr>
<tr>
<td>28555</td>
<td>Open treatment of tarsal bone dislocation, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0503</td>
<td>9.65</td>
<td>60</td>
<td>281</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>242</td>
</tr>
<tr>
<td>29906</td>
<td>Arthroscopy, subtalar joint, surgical; with debridement</td>
<td>090</td>
<td>0.0662</td>
<td>9.65</td>
<td>60</td>
<td>244</td>
<td>2007-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>139</td>
</tr>
<tr>
<td>27784</td>
<td>Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0507</td>
<td>9.67</td>
<td>60</td>
<td>281</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>423</td>
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<tr>
<td>24575</td>
<td>Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0357</td>
<td>9.71</td>
<td>60</td>
<td>308</td>
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<td>ORTHOPEDIC SURGERY</td>
<td>125</td>
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<tr>
<td>50590</td>
<td>Lithotripsy, extracorporeal shock wave</td>
<td>090</td>
<td>0.0908</td>
<td>9.77</td>
<td>60</td>
<td>207</td>
<td>2012-04</td>
<td>UROLOGY</td>
<td>54658</td>
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<tr>
<td>42145</td>
<td>Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
<td>090</td>
<td>0.0613</td>
<td>9.78</td>
<td>60</td>
<td>262</td>
<td>2008-04</td>
<td>OTOLARYNGOLOGY</td>
<td>518</td>
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<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)</td>
<td>090</td>
<td>0.0533</td>
<td>9.90</td>
<td>60</td>
<td>281</td>
<td>2005-08</td>
<td>PLASTIC AND RECONSTRUCTIVE SURGERY</td>
<td>13549</td>
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<tr>
<td>24164</td>
<td>Removal of prosthesis, includes debridement and synovectomy when performed; radial head</td>
<td>090</td>
<td>0.0812</td>
<td>10.00</td>
<td>60</td>
<td>228</td>
<td>2013-01</td>
<td>ORTHOPEDIC SURGERY</td>
<td>103</td>
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<td>CPT Code</td>
<td>Description</td>
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<td>Rate</td>
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<td>Rate</td>
<td>Year</td>
<td>Specialty</td>
<td>Code</td>
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<td></td>
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<tr>
<td>57240</td>
<td>Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed</td>
<td>090</td>
<td>0.0965</td>
<td>10.08</td>
<td>60</td>
<td>211</td>
<td>2017-01</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>9026</td>
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<tr>
<td>57250</td>
<td>Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy</td>
<td>090</td>
<td>0.0965</td>
<td>10.08</td>
<td>60</td>
<td>211</td>
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<td>OBSTETRICS/GYNECOLOGY</td>
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<tr>
<td>19301</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);</td>
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<td>0.0934</td>
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<td>GENERAL SURGERY</td>
<td>62740</td>
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<tr>
<td>43284</td>
<td>Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed</td>
<td>090</td>
<td>0.0947</td>
<td>10.13</td>
<td>60</td>
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<td>2016-01</td>
<td>GENERAL SURGERY</td>
<td>28</td>
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<tr>
<td>27769</td>
<td>Open treatment of posterior malleolus fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0648</td>
<td>10.14</td>
<td>60</td>
<td>279</td>
<td>2007-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>208</td>
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<tr>
<td>23430</td>
<td>Tenodesis of long tendon of biceps</td>
<td>090</td>
<td>0.0842</td>
<td>10.17</td>
<td>60</td>
<td>237</td>
<td>2009-10</td>
<td>ORTHOPEDIC SURGERY</td>
<td>19997</td>
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<tr>
<td>15240</td>
<td>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</td>
<td>090</td>
<td>0.0528</td>
<td>10.41</td>
<td>60</td>
<td>288</td>
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<td>DERMATOLOGY</td>
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<tr>
<td>44950</td>
<td>Appendectomy</td>
<td>090</td>
<td>0.0778</td>
<td>10.60</td>
<td>60</td>
<td>252</td>
<td>2000-08</td>
<td>GENERAL SURGERY</td>
<td>1101</td>
</tr>
<tr>
<td>28615</td>
<td>Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0426</td>
<td>10.70</td>
<td>60</td>
<td>323</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>1662</td>
</tr>
<tr>
<td>27248</td>
<td>Open treatment of greater trochanteric fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0198</td>
<td>10.78</td>
<td>60</td>
<td>384</td>
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<td>ORTHOPEDIC SURGERY</td>
<td>1248</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
<td>090</td>
<td>0.0943</td>
<td>11.00</td>
<td>60</td>
<td>243</td>
<td>2009-04</td>
<td>NEUROSURGERY</td>
<td>2414</td>
</tr>
<tr>
<td>27826</td>
<td>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</td>
<td>090</td>
<td>0.0484</td>
<td>11.10</td>
<td>60</td>
<td>328</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>174</td>
</tr>
<tr>
<td>41120</td>
<td>Glossectomy; less than one-half tongue</td>
<td>090</td>
<td>0.0715</td>
<td>11.14</td>
<td>60</td>
<td>278</td>
<td>2005-08</td>
<td>OTOLARYNGOLOGY</td>
<td>2232</td>
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<tr>
<td>57287</td>
<td>Removal or revision of sling for stress incontinence (eg, fascia or synthetic)</td>
<td>090</td>
<td>0.0942</td>
<td>11.15</td>
<td>60</td>
<td>239</td>
<td>2010-10</td>
<td>OBSTETRICS/GYNECOLOGY</td>
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<td>65850</td>
<td>Trabeculotomy ab externo</td>
<td>090</td>
<td>0.1109</td>
<td>11.39</td>
<td>60</td>
<td>233</td>
<td>2005-08</td>
<td>OPHTHALMOLOGY</td>
<td>620</td>
</tr>
<tr>
<td>54437</td>
<td>Repair of traumatic corporeal tear(s)</td>
<td>090</td>
<td>0.0872</td>
<td>11.50</td>
<td>60</td>
<td>264</td>
<td>2015-01</td>
<td>UROLOGY</td>
<td>54</td>
</tr>
<tr>
<td>57285</td>
<td>Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach</td>
<td>090</td>
<td>0.0923</td>
<td>11.60</td>
<td>60</td>
<td>267</td>
<td>2007-04</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>986</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Specialty Otolaryngology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2979</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
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<td>0.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty Otolaryngology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>900</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>
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. 31070
CPT Code: 69717

Tracking Number

Original Specialty Recommended RVU: 11.48

Presented Recommended RVU: 8.80

RUC Recommended RVU: 8.80

CPT Descriptor: Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor

**AMERICAN MEDICAL ASSOCIATION'S SOCIAL SECURITY WAGE BASE UPDATE PROJECTION**

**SUMMARY OF RECOMMENDATION**

CPT Code: 69717

Global Period: 090

Current Work RVU: 15.43

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: 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>69717</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>533</td>
</tr>
<tr>
<td>Resp N:</td>
<td>64</td>
</tr>
</tbody>
</table>

**Description of Sample:** Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

#### Service Performance Rate

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
<td>2.00</td>
<td>10.00</td>
</tr>
</tbody>
</table>

#### Survey RVW

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.00</td>
<td>11.48</td>
<td>12.50</td>
<td>14.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

#### Pre-Service Evaluation Time:

| 10.00 |

#### 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**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>69.00 99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit:** 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 9911 (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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>69717</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>8.80</td>
</tr>
</tbody>
</table>

| 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

| Immediate Post Service-Time: | 15.00 | 30.00 | -15.00 |
CPT Code: 69717

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>62.00</td>
<td>99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15260</td>
<td>090</td>
<td>11.64</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15120</td>
<td>090</td>
<td>10.15</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>67904</td>
<td>090</td>
<td>7.97</td>
<td>RUC Time</td>
<td>54,853</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>26615</td>
<td>090</td>
<td>7.07</td>
<td>RUC Time</td>
<td>1,057,533</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

**Other Reference CPT Code**

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>66183</td>
<td>090</td>
<td>13.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 69717</th>
<th>Top Key Reference CPT Code: 15260</th>
<th>2nd Key Reference CPT Code: 15120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>46.00</td>
<td>28.00</td>
<td>72.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>100.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>62.00</td>
<td>115.00</td>
<td>62.00</td>
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<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>187.00</td>
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<td>258.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
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</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>22%</td>
<td>67%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>33%</td>
<td>66%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
<td>Technical skill required</td>
<td>11%</td>
<td>22%</td>
<td>67%</td>
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<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Psychological Stress</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
</tr>
<tr>
<td>----------------------</td>
<td>------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Key Reference Code</th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>11%</td>
<td>0%</td>
<td>33%</td>
<td>44%</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>22%</td>
<td>33%</td>
<td>44%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>33%</td>
<td>22%</td>
<td>44%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>44%</td>
<td>33%</td>
<td>22%</td>
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</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 patient's 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>IWPUT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
<th>2019 Medicare Allowed Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>45171</td>
<td>Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)</td>
<td>090</td>
<td>0.0761</td>
<td>8.13</td>
<td>45</td>
<td>209</td>
<td>2009-02</td>
<td>COLORECTAL SURGERY (PROCTOLOGY)</td>
<td>2516</td>
<td>1560949</td>
</tr>
<tr>
<td>52500</td>
<td>Transurethral resection of bladder neck (separate procedure)</td>
<td>090</td>
<td>0.0582</td>
<td>8.14</td>
<td>45</td>
<td>230.5</td>
<td>2008-04</td>
<td>UROLOGY</td>
<td>3173</td>
<td>1544895</td>
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<td>25606</td>
<td>Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation</td>
<td>090</td>
<td>0.0419</td>
<td>8.31</td>
<td>45</td>
<td>260</td>
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<td>ORTHOPEDIC SURGERY</td>
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<td>67255</td>
<td>Scleral reinforcement (separate procedure); with graft</td>
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<td>0.0595</td>
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<td>45</td>
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<td>OPHTHALMOLOGY</td>
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<td>45020</td>
<td>Incision and drainage of deep supravelvator, pelvirectal, or retrorectal abscess</td>
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<td>GENERAL SURGERY</td>
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<td>110926</td>
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<tr>
<td>27829</td>
<td>Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0457</td>
<td>8.80</td>
<td>45</td>
<td>271</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>7628</td>
<td>3853250</td>
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<tr>
<td>31610</td>
<td>Tracheostomy, fenestration procedure with skin flaps</td>
<td>090</td>
<td>0.0278</td>
<td>12.00</td>
<td>45</td>
<td>367</td>
<td>2016-10</td>
<td>OTOLARYNGOLOGY</td>
<td>1593</td>
<td>1406921</td>
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<tr>
<td>66183</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach</td>
<td>090</td>
<td>0.126</td>
<td>13.20</td>
<td>45</td>
<td>257</td>
<td>2013-04</td>
<td>OPHTHALMOLOGY</td>
<td>4674</td>
<td>4894644</td>
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<tr>
<td>66170</td>
<td>Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery</td>
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<td>0.1293</td>
<td>13.94</td>
<td>45</td>
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<td>2015-04</td>
<td>OPHTHALMOLOGY</td>
<td>6957</td>
<td>7907614</td>
</tr>
</tbody>
</table>

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.
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 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? 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 estimate 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

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:
Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix \textit{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 \textit{will} change, please select another crosswalk based on a similar specialty mix.
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 69719
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 patient’s 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 patient’s 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>69719</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
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<tbody>
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<td>2.00</td>
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<tr>
<td>Survey RVW:</td>
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<td>12.00</td>
<td>13.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
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<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Intra-Service Time:</td>
<td>14.00</td>
<td>43.00</td>
<td>60.00</td>
<td>80.00</td>
<td>201.00</td>
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<tr>
<td>Immediate Post Service-Time:</td>
<td><strong>15.00</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative 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 |

**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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
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<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
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<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
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<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
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<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
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<td>30.00</td>
<td>-15.00</td>
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</table>
CPT Code: 69719

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
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<tbody>
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<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>46.00</td>
<td>99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00</td>
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<td>Prolonged Services:</td>
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<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
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<tr>
<td>Sub Obs Care:</td>
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<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
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**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
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<tbody>
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<td>12.00</td>
<td>RUC Time</td>
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CPT Descriptor: Tracheostomy, fenestration procedure with skin flaps

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
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<td>15730</td>
<td>090</td>
<td>13.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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<tbody>
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<td>57288</td>
<td>090</td>
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<td>RUC Time</td>
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</table>

CPT Descriptor: Sling operation for stress incontinence (eg, fascia or synthetic)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
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<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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<tbody>
<tr>
<td>54437</td>
<td>090</td>
<td>11.50</td>
<td>RUC Time</td>
<td>54</td>
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CPT Descriptor: Repair of traumatic corporeal tear(s)

**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)

<table>
<thead>
<tr>
<th>CPT Code: 69719</th>
<th>Top Key Reference CPT Code: 31610</th>
<th>2nd Key Reference CPT Code: 15730</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>46.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>173.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>46.00</td>
<td>69.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>186.00</td>
<td>367.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>38%</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>63%</td>
<td>37%</td>
</tr>
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</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>13%</td>
<td>75%</td>
<td>13%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>71%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>IWPUT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>25607</td>
<td>Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation</td>
<td>090</td>
<td>0.0523</td>
<td>9.56</td>
<td>60</td>
<td>275</td>
<td>2006-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>9419</td>
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<tr>
<td>26356</td>
<td>Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon</td>
<td>090</td>
<td>0.0551</td>
<td>9.56</td>
<td>60</td>
<td>277</td>
<td>2015-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>1150</td>
</tr>
<tr>
<td>66184</td>
<td>Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft</td>
<td>090</td>
<td>0.0485</td>
<td>9.58</td>
<td>60</td>
<td>254</td>
<td>2014-01</td>
<td>OPHTHALMOLOGY</td>
<td>594</td>
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<tr>
<td>28555</td>
<td>Open treatment of tarsal bone dislocation, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0503</td>
<td>9.65</td>
<td>60</td>
<td>281</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>242</td>
</tr>
<tr>
<td>29906</td>
<td>Arthroscopy, subtalar joint, surgical; with debridement</td>
<td>090</td>
<td>0.0662</td>
<td>9.65</td>
<td>60</td>
<td>244</td>
<td>2007-04</td>
<td>ORTHOPEDIC SURGERY</td>
<td>139</td>
</tr>
<tr>
<td>27784</td>
<td>Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0507</td>
<td>9.67</td>
<td>60</td>
<td>281</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>423</td>
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<tr>
<td>24575</td>
<td>Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0357</td>
<td>9.71</td>
<td>60</td>
<td>308</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>125</td>
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<tr>
<td>50590</td>
<td>Lithotripsy, extracorporeal shock wave</td>
<td>090</td>
<td>0.0908</td>
<td>9.77</td>
<td>60</td>
<td>207</td>
<td>2012-04</td>
<td>UROLOGY</td>
<td>54658</td>
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<tr>
<td>42145</td>
<td>Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
<td>090</td>
<td>0.0613</td>
<td>9.78</td>
<td>60</td>
<td>262</td>
<td>2008-04</td>
<td>OTOLARYNGOLOGY</td>
<td>518</td>
</tr>
<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)</td>
<td>090</td>
<td>0.0533</td>
<td>9.90</td>
<td>60</td>
<td>281</td>
<td>2005-08</td>
<td>PLASTIC AND RECONSTRUCTIVE SURGERY</td>
<td>13549</td>
</tr>
<tr>
<td>24164</td>
<td>Removal of prosthesis, includes debridement and synovectomy when performed; radial head</td>
<td>090</td>
<td>0.0812</td>
<td>10.00</td>
<td>60</td>
<td>228</td>
<td>2013-01</td>
<td>ORTHOPEDIC SURGERY</td>
<td>103</td>
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<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Value</td>
<td>Units</td>
<td>Modifier</td>
<td>Service Date</td>
<td>Specialty</td>
<td>Code</td>
<td></td>
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<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
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<td></td>
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</tr>
<tr>
<td>57240</td>
<td>Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed</td>
<td>090</td>
<td>0.0965</td>
<td>10.08</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>9026</td>
<td></td>
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<tr>
<td>57250</td>
<td>Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy</td>
<td>090</td>
<td>0.0965</td>
<td>10.08</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>8757</td>
<td></td>
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<tr>
<td>19301</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);</td>
<td>090</td>
<td>0.0934</td>
<td>10.13</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>62740</td>
<td></td>
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<tr>
<td>43284</td>
<td>Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed</td>
<td>090</td>
<td>0.0947</td>
<td>10.13</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>28</td>
<td></td>
<td></td>
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<tr>
<td>27769</td>
<td>Open treatment of posterior malleolus fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0648</td>
<td>10.14</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>208</td>
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<tr>
<td>23430</td>
<td>Tenodesis of long tendon of biceps</td>
<td>090</td>
<td>0.0842</td>
<td>10.17</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>19997</td>
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<tr>
<td>15240</td>
<td>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</td>
<td>090</td>
<td>0.0528</td>
<td>10.41</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>13328</td>
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<tr>
<td>44950</td>
<td>Appendectomy;</td>
<td>090</td>
<td>0.0778</td>
<td>10.60</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>1101</td>
<td></td>
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<tr>
<td>28615</td>
<td>Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0426</td>
<td>10.70</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>1662</td>
<td></td>
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<tr>
<td>27248</td>
<td>Open treatment of greater trochanteric fracture, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0198</td>
<td>10.78</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>1248</td>
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<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminctomy, including fluoroscopy, when performed</td>
<td>090</td>
<td>0.0943</td>
<td>11.00</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>2414</td>
<td></td>
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<tr>
<td>27826</td>
<td>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</td>
<td>090</td>
<td>0.0484</td>
<td>11.10</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>174</td>
<td></td>
<td></td>
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<tr>
<td>41120</td>
<td>Glossectomy, less than one-half tongue</td>
<td>090</td>
<td>0.0715</td>
<td>11.14</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>2232</td>
<td></td>
<td></td>
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<tr>
<td>57287</td>
<td>Removal or revision of sling for stress incontinence (eg, fascia or synthetic)</td>
<td>090</td>
<td>0.0942</td>
<td>11.15</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>1737</td>
<td></td>
<td></td>
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<tr>
<td>65850</td>
<td>Trabeculotomy ab externo</td>
<td>090</td>
<td>0.1109</td>
<td>11.39</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>620</td>
<td></td>
<td></td>
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<tr>
<td>54437</td>
<td>Repair of traumatic corporeal tear(s) (including repair of cystocele, if performed); vaginal approach</td>
<td>090</td>
<td>0.0872</td>
<td>11.50</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>54</td>
<td></td>
<td></td>
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<tr>
<td>57285</td>
<td>Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach</td>
<td>090</td>
<td>0.0923</td>
<td>11.60</td>
<td>60</td>
<td>OBSTETRICS/GYNECOLOGY</td>
<td>986</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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? 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

<table>
<thead>
<tr>
<th>Specialty Otolaryngology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty Otolaryngology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>
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. 31070
CPT Code: 69726 Tracking Number:  
Original Specialty Recommended RVU: 10.00
Presented Recommended RVU: 5.93
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 subperiocular dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseointegrated 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).

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
<td>2.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>5.00</td>
<td>10.00</td>
<td>10.90</td>
<td>12.00</td>
<td>20.45</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td>32.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>20.00</td>
<td>30.00</td>
<td>45.00</td>
<td>187.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 15.00  

**Post Operative Visits**  
<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Critical Care time/visit(s):</th>
<th>Other Hospital time/visit(s):</th>
<th>Discharge Day Mgmt:</th>
<th>Office time/visit(s):</th>
<th>Prolonged Services:</th>
<th>Sub Obs Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>99291x 0.00</td>
<td>99231x 0.00</td>
<td>99238x 0.00</td>
<td>99238x 0.00</td>
<td>99211x 39.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>32.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td></td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 15.00  

**9A General Anes or Complex Reg Blk/Strghtforw Proc**

<table>
<thead>
<tr>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>15.00</td>
<td>-15.00</td>
</tr>
</tbody>
</table>
### Post-Operative Visits

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
<th>CPT Code  and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>39.00</td>
<td>99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15120</td>
<td>090</td>
<td>10.15</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>66185</td>
<td>090</td>
<td>10.58</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>67904</td>
<td>090</td>
<td>7.97</td>
<td>RUC Time</td>
<td>54,853</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>26615</td>
<td>090</td>
<td>7.07</td>
<td>RUC Time</td>
<td>1,057,533</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

### Other Reference CPT Code

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>27829</td>
<td>090</td>
<td>8.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 69726</th>
<th>Top Key Reference CPT Code: 15120</th>
<th>2nd Key Reference CPT Code: 66185</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>45.00</td>
<td>72.00</td>
<td>25.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>75.00</td>
<td>65.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>30.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>19.00</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>39.00</td>
<td>62.00</td>
<td>140.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>148.00</td>
<td>258.00</td>
<td>259.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>7%</td>
<td>31%</td>
<td>48%</td>
<td>14%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Effort and Judgment</td>
<td>31%</td>
<td>41%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>45%</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>34%</td>
<td>38%</td>
<td>27%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>44%</td>
<td>48%</td>
<td>6%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td>38%</td>
<td>62%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>Less</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td>More</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>63%</td>
<td>38%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>26%</td>
<td>63%</td>
<td>13%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td>38%</td>
<td>62%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>63%</td>
<td>38%</td>
<td>0%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### 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 **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
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>IWPUT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>46262</td>
<td>Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed</td>
<td>090</td>
<td>0.0888</td>
<td>7.91</td>
<td>45</td>
<td>179</td>
<td>2000</td>
<td>General Surgery</td>
<td>106</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach</td>
<td>090</td>
<td>0.0892</td>
<td>7.97</td>
<td>45</td>
<td>185</td>
<td>2005</td>
<td>Ophthalmology</td>
<td>54853</td>
</tr>
<tr>
<td>45171</td>
<td>Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)</td>
<td>090</td>
<td>0.0761</td>
<td>8.13</td>
<td>45</td>
<td>209</td>
<td>2009-02</td>
<td>COLORECTAL SURGERY (PROCTOLOGY)</td>
<td>2516</td>
</tr>
<tr>
<td>52500</td>
<td>Transurethral resection of bladder neck (separate procedure)</td>
<td>090</td>
<td>0.0582</td>
<td>8.14</td>
<td>45</td>
<td>230.5</td>
<td>2008-04</td>
<td>UROLOGY</td>
<td>3173</td>
</tr>
<tr>
<td>25606</td>
<td>Percutaneous skeletal fixation of distal radial fracture or epiphysial separation</td>
<td>090</td>
<td>0.0419</td>
<td>8.31</td>
<td>45</td>
<td>260</td>
<td>2006-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>2015</td>
</tr>
<tr>
<td>67255</td>
<td>Scleral reinforcement (separate procedure); with graft</td>
<td>090</td>
<td>0.0595</td>
<td>8.38</td>
<td>45</td>
<td>216</td>
<td>2014-01</td>
<td>OPHTHALMOLOGY</td>
<td>833</td>
</tr>
<tr>
<td>45020</td>
<td>Incision and drainage of deep supraventricular, pelvicrectal, or retrorectal abscess</td>
<td>090</td>
<td>0.0511</td>
<td>8.56</td>
<td>45</td>
<td>255</td>
<td>2005-08</td>
<td>GENERAL SURGERY</td>
<td>199</td>
</tr>
<tr>
<td>27829</td>
<td>Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0457</td>
<td>8.80</td>
<td>45</td>
<td>271</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>7628</td>
</tr>
<tr>
<td>31610</td>
<td>Tracheostomy, fenestration procedure with skin flaps</td>
<td>090</td>
<td>0.0278</td>
<td>12.00</td>
<td>45</td>
<td>367</td>
<td>2016-10</td>
<td>OTOLARYNGOLOGY</td>
<td>1593</td>
</tr>
<tr>
<td>66183</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach</td>
<td>090</td>
<td>0.126</td>
<td>13.20</td>
<td>45</td>
<td>257</td>
<td>2013-04</td>
<td>OPHTHALMOLOGY</td>
<td>4674</td>
</tr>
<tr>
<td>66170</td>
<td>Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery</td>
<td>090</td>
<td>0.1293</td>
<td>13.94</td>
<td>45</td>
<td>278</td>
<td>2015-04</td>
<td>OPHTHALMOLOGY</td>
<td>6957</td>
</tr>
</tbody>
</table>

**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.
CPT Code: 69726

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otolaryngology</td>
<td>Rarely</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otolaryngology</td>
<td>3</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otolaryngology</td>
<td>1</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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
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
CPT Code: 69727

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
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 the 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 subperiosteal dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseointegrated 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Peter Manes, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAO-HNS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>69727</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
<td>10.00</td>
</tr>
</tbody>
</table>

| 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 |

<table>
<thead>
<tr>
<th>Post Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>39.00</td>
<td>99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>33.00</td>
<td>33.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>10.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>45.00</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>15.00</td>
<td>30.00</td>
</tr>
</tbody>
</table>
**Post-Operative Visits**

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x</td>
<td>0.5</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>39.00</td>
<td>99211x</td>
<td>12x 1.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15120</td>
<td>090</td>
<td>10.15</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>41120</td>
<td>090</td>
<td>11.14</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>67904</td>
<td>090</td>
<td>7.97</td>
<td>RUC Time</td>
<td>54,853</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>28003</td>
<td>090</td>
<td>9.06</td>
<td>RUC Time</td>
<td>5,470</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

**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)

<table>
<thead>
<tr>
<th>CPT Code: 69727</th>
<th>Top Key Reference CPT Code: 15120</th>
<th>2nd Key Reference CPT Code: 41120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>46.00</td>
<td>72.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>19.00</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>39.00</td>
<td>62.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>164.00</td>
<td>258.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>38%</td>
<td>38%</td>
<td>23%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>46%</td>
<td>39%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>46%</td>
<td>15%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Technical skill required

Physical effort required

Technical skill required

Physical effort required
<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31%</td>
<td>46%</td>
<td>23%</td>
</tr>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Key Reference Code</th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>Less</td>
<td>Less</td>
<td>0%</td>
<td>38%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>38%</td>
<td>50%</td>
<td>12%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>38%</td>
<td>50%</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>63%</td>
<td>38%</td>
<td>0%</td>
</tr>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>IWPHT</th>
<th>Work RVU</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Most Recent RUC Review</th>
<th>Top_Specialty</th>
<th>2019 Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>46262</td>
<td>Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed</td>
<td>090</td>
<td>0.0888</td>
<td>7.91</td>
<td>45</td>
<td>179</td>
<td>2000</td>
<td>General Surgery</td>
<td>106</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
<td>090</td>
<td>0.0892</td>
<td>7.97</td>
<td>45</td>
<td>185</td>
<td>2005</td>
<td>Ophthalmology</td>
<td>54853</td>
</tr>
<tr>
<td>45171</td>
<td>Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)</td>
<td>090</td>
<td>0.0761</td>
<td>8.13</td>
<td>45</td>
<td>209</td>
<td>2009-02</td>
<td>COLORECTAL SURGERY (PROCTOLOGY)</td>
<td>2516</td>
</tr>
<tr>
<td>52500</td>
<td>Transurethral resection of bladder neck (separate procedure)</td>
<td>090</td>
<td>0.0582</td>
<td>8.14</td>
<td>45</td>
<td>230.5</td>
<td>2008-04</td>
<td>UROLOGY</td>
<td>3173</td>
</tr>
<tr>
<td>25606</td>
<td>Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation</td>
<td>090</td>
<td>0.0419</td>
<td>8.31</td>
<td>45</td>
<td>260</td>
<td>2006-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>2015</td>
</tr>
<tr>
<td>67255</td>
<td>Scleral reinforcement (separate procedure); with graft</td>
<td>090</td>
<td>0.0595</td>
<td>8.38</td>
<td>45</td>
<td>216</td>
<td>2014-01</td>
<td>OPHTHALMOLOGY</td>
<td>833</td>
</tr>
<tr>
<td>45020</td>
<td>Incision and drainage of deep supravelevator, pelvirectal, or retrorectal abscess</td>
<td>090</td>
<td>0.0511</td>
<td>8.56</td>
<td>45</td>
<td>255</td>
<td>2005-08</td>
<td>GENERAL SURGERY</td>
<td>199</td>
</tr>
<tr>
<td>27829</td>
<td>Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed</td>
<td>090</td>
<td>0.0457</td>
<td>8.80</td>
<td>45</td>
<td>271</td>
<td>2007-02</td>
<td>ORTHOPEDIC SURGERY</td>
<td>7628</td>
</tr>
<tr>
<td>31610</td>
<td>Tracheostomy, fenestration procedure with skin flaps</td>
<td>090</td>
<td>0.0278</td>
<td>12.00</td>
<td>45</td>
<td>367</td>
<td>2016-10</td>
<td>OTOLARYNGOLOGY</td>
<td>1593</td>
</tr>
<tr>
<td>66183</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach</td>
<td>090</td>
<td>0.126</td>
<td>13.20</td>
<td>45</td>
<td>257</td>
<td>2013-04</td>
<td>OPHTHALMOLOGY</td>
<td>4674</td>
</tr>
<tr>
<td>66170</td>
<td>Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery</td>
<td>090</td>
<td>0.1293</td>
<td>13.94</td>
<td>45</td>
<td>278</td>
<td>2015-04</td>
<td>OPHTHALMOLOGY</td>
<td>6957</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otoloaryngology</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otoloaryngology</td>
<td>27</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otoloaryngology</td>
<td>9</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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
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
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystourethroscopy with incision, fulguration</td>
<td>54613</td>
<td></td>
</tr>
<tr>
<td>Transient Tarsorrhaphy, right eye</td>
<td>39718</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy, fenestration procedure with Glossectomy; less than one-half tongue</td>
<td>45989</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy, fenestration procedure with Glossectomy; less than one-half tongue</td>
<td>45989</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy, fenestration procedure with Glossectomy; less than one-half tongue</td>
<td>45989</td>
<td></td>
</tr>
<tr>
<td>Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, mouth, neck, genitalia, hands, external speech processor, osseointegrated implant, skull; with percutaneous attachment to external speech processor by radiofrequency thermotherapy</td>
<td>61480</td>
<td></td>
</tr>
<tr>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor</td>
<td>61496</td>
<td></td>
</tr>
<tr>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor</td>
<td>61496</td>
<td></td>
</tr>
</tbody>
</table>

**ISSUE:** Transcutaneous Passive Implant Temporal Bone (BAHA)

**TAB:** 18

**SS Rec Summary**

- **MIN 25th MED 75th MAX**
  - **Time**
    - **PRE-TIME**
      - **POST**
        - **Office**
Meeting Date: January 2021

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>69714</td>
<td>Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
<tr>
<td>69716</td>
<td>Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
<tr>
<td>69717</td>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
<tr>
<td>69719</td>
<td>Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
<tr>
<td>69726</td>
<td>Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
<tr>
<td>69727</td>
<td>Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor</td>
<td>090</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>69714</td>
<td>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.</td>
</tr>
<tr>
<td>69716</td>
<td>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.</td>
</tr>
</tbody>
</table>
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: 69717

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: 69719

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: 69726

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.

CPT Code: 69727

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/stapes 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
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.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Code</th>
<th>Unit</th>
<th>Item</th>
<th>Qty</th>
<th>Unit price</th>
</tr>
</thead>
<tbody>
<tr>
<td>pack, minimum multi-specialty visit</td>
<td>SA048</td>
<td>pack</td>
<td></td>
<td>4.0507</td>
<td></td>
</tr>
<tr>
<td>paper, exam table</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>gloves, non-sterile</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>gown, patient</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>pillow case</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>cover, thermometer probe</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>pack, cleaning, surgical instruments</td>
<td>SA043</td>
<td>pack</td>
<td></td>
<td>10.7922</td>
<td></td>
</tr>
<tr>
<td>gloves, non-sterile</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>gown, staff, impervious</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>face shield, splash protection</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>autoclave bag</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>autoclave tape</td>
<td></td>
<td>yd</td>
<td></td>
<td>0.33</td>
<td></td>
</tr>
<tr>
<td>enzymatic detergent</td>
<td></td>
<td>oz</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>cleaning brush, instruments</td>
<td></td>
<td>item</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>pack, post-op incision care (suture)</td>
<td>SA054</td>
<td>pack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>kit, suture removal</td>
<td></td>
<td>kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>povidone soln (Betadine)</td>
<td></td>
<td>ml</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gauze, sterile 4in x 4in</td>
<td></td>
<td>item</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gloves, sterile</td>
<td></td>
<td>pair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>steri-strip (6 strip uou)</td>
<td></td>
<td>item</td>
<td></td>
<td></td>
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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 Latitude 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 suction, 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.
### Clinical Activity Code: 
**CA001 - Pre-Service Period**

#### Start: When patient enters office/facility for surgery/procedure:

#### End: When patient enters office/facility for surgery/procedure

### Service Period (L037D)

#### Start: When patient enters office/facility for surgery/procedure:

#### End: Patient leaves office/facility

### Post-Service Period

#### End: Patient leaves office/facility

### Staff Type: Clinical Staff

#### Rate: $

### Location: Arching

**Cost: $99213**

**Duration:** 36 minutes

### Activity Code: CA015 - Implant, temporal bone; with speech processor

#### Location: Arching

**Cost: $99212**

**Duration:** 27 minutes

### Activity Code: CA013 - Implant, skull; with speech processor

#### Location: Arching

**Cost: $99211**

**Duration:** 16 minutes

### Other Activity: Please include short clinical description here and type

#### Location: Arching

**Cost: $99211**

**Duration:** 16 minutes

### RUC Collaboration Website

#### Specialty: AAO-HNS

#### Revision Date (if applicable): 

#### Meeting Date: January 2021

#### Revision Date: 18

#### Revision Date: January 2021

#### Revision Date: 18

#### Revision Date: January 2021

#### Revision Date: 18

#### Revision Date: January 2021

#### Revision Date: 18

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#### Revision Date: January 2021

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CPT Code 69714

- **Implantation**, osseointegrated
- **Bone**; with **speech processor**
- **Attachment to external implant**, temporal

CPT Code 69715

- **Revision/replacement** (including removal of existing device), osseointegrated
- **Implant**, temporal

CPT Code 69716

- **Revision/replacement** (including removal of existing device), osseointegrated
- **Implant**, skull; with **speech processor**

CPT Code 69717

- **Revision/replacement** (including removal of existing device), osseointegrated
- **Implant**, skull; with **existing device**

CPT Code 69727

- **Revision/replacement** (including removal of existing device), osseointegrated
- **Implant**, temporal

For the purpose of estimating the cost per minute, please include the type of unit (oz, ml, unit). Please note that you must include a purchase price estimate consistent with the paid invoice in column D.

### Equipment Costs

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For new equipment items, please include the type of unit (oz, ml, unit). Please note that you must include a purchase price estimate consistent with the paid invoice in column D.
The RUC identified CPT code 93656 with Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019. 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
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 transcatheater 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 transcatheater 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 electrophysiologie 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.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 transcatheater 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 transcatheater 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.
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.
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.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>93613</td>
<td>Y1</td>
<td>Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>5.23 (No Change) (Affirmed February 2017 RUC recommendation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Use 93613 in conjunction with 93620, 93653, 93656)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 93613 in conjunction with 93609, 93654)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93621</td>
<td>Y2</td>
<td>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)</td>
<td>ZZZ</td>
<td>1.75 (Affirmed October 2020 RUC recommendation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Use 93621 in conjunction with 93620, 93653, 93654)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 93621 in conjunction with 93656)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲93653</td>
<td>Y3</td>
<td>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, 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, 93620, 93621, 93642, 93654, 93656)</td>
<td>000</td>
<td>15.00</td>
</tr>
<tr>
<td>▲93654</td>
<td>Y4</td>
<td>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)</td>
<td>000</td>
<td>18.10</td>
</tr>
<tr>
<td>(f)93655</td>
<td>Y5</td>
<td>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)</td>
<td>ZZZ</td>
<td>7.00</td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Resource Unit (RU)</th>
<th>Relative Value (RV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>93656</td>
<td>Y6</td>
<td>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)</td>
<td>000</td>
<td>17.00</td>
</tr>
<tr>
<td>(f)93657</td>
<td>Y7</td>
<td>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)</td>
<td>ZZZ</td>
<td>7.00</td>
</tr>
<tr>
<td>+93662</td>
<td>Y8</td>
<td>Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>2.53</td>
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</tbody>
</table>

(Affirmed May 2019 RUC recommendation)
<table>
<thead>
<tr>
<th>Procedure/Services included with Ablations</th>
<th>93653 SVT Ablation</th>
<th>93654 VT Ablation</th>
<th>93656 AF Ablation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inherent</td>
<td>Bundled</td>
<td>Not Bundled, Sometimes Performed</td>
</tr>
<tr>
<td>Insert/reposition multiple catheters</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transseptal catheterization(s) (93462)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction or attempted induction of arrhythmia with Right Atrial pacing and recording</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intracardiac ablation of arrhythmia</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SVT Ablation</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VT Ablation</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF Ablation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intracardiac 3d mapping (93613)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Right Ventricular pacing and recording</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Left Atrial pacing and recording from coronary sinus or Left Atrium (93612)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>His Bundle recording</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Left Ventricular pacing and recording</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Intracardiac Echocardiography (93662)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
CPT Code: 93653  Tracking Number  Y1

Original Specialty Recommended RVU: **15.00**  
Presented Recommended RVU: **15.00**  
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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital %</th>
<th>In the ASC %</th>
<th>In the office %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day %, Overnight stay-less than 24 hours %, Overnight stay-more than 24 hours %

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day</th>
<th>0%</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
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<td>25.00</td>
<td>40.00</td>
<td>50.00</td>
<td>200.00</td>
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<tr>
<td>Survey RVW:</td>
<td>7.25</td>
<td>15.00</td>
<td>18.00</td>
<td>23.25</td>
<td>37.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td>31.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Immediate Post Service-Time-Time:</td>
<td></td>
<td></td>
<td>30.00</td>
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<tr>
<td>Post Operative Visits</td>
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<tr>
<td>Critical Care time/visit(s):</td>
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<td>0.00</td>
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<tr>
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<td>0.00</td>
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<td>Discharge Day Mgmt:</td>
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<td>0.00</td>
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<tr>
<td>Office time/visit(s):</td>
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<td>0.00</td>
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<td>Prolonged Services:</td>
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<td>0.00</td>
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<td>0.00</td>
<td>99225x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th><strong>CPT Code:</strong></th>
<th>93653</th>
<th><strong>Recommended Physician Work RVU:</strong> 15.00</th>
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<tbody>
<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>31.00</td>
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<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
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<td>3.00</td>
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<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
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<td>20.00</td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>120.00</td>
<td></td>
</tr>
</tbody>
</table>

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

| **Immediate Post Service-Time:** | 30.00 | 33.00 | -3.00 |
**CPT Code: 93653**

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
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<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
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<td>99238x 0.00 99239x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
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<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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</thead>
<tbody>
<tr>
<td>93580</td>
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<td>17.97</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>33340</td>
<td>000</td>
<td>14.00</td>
<td>RUC Time</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraoperative roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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<tbody>
<tr>
<td>0.00</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 93653</th>
<th>Top Key Reference CPT Code: 93580</th>
<th>2nd Key Reference CPT Code: 33340</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>58.00</td>
<td>30.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>125.00</td>
<td>120.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
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<td>60.00</td>
<td>30.00</td>
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<tr>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
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<tr>
<td>Median Office Visit Time</td>
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</tr>
<tr>
<td>Prolonged Services Time</td>
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</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
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<tr>
<td>Median Total Time</td>
<td>213.00</td>
<td>210.00</td>
<td>160.00</td>
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<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
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<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>45%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>25%</td>
<td>75%</td>
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Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
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<tbody>
<tr>
<td>5%</td>
<td>10%</td>
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Physical effort required

<table>
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</thead>
<tbody>
<tr>
<td>0%</td>
<td>40%</td>
<td>60%</td>
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</table>
**Psychological Stress**

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>
- 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

**2nd Key Reference Code**

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<th>Much</th>
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</thead>
<tbody>
<tr>
<td>Less</td>
<td>6%</td>
<td>19%</td>
<td>50%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>6%</td>
<td>19%</td>
<td>50%</td>
<td>25%</td>
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</table>

**Mental Effort and Judgment**

<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>
- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Technical skill required</td>
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<td>47%</td>
<td>53%</td>
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<tr>
<td>Physical effort required</td>
<td>13%</td>
<td>34%</td>
<td>53%</td>
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</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13%</td>
<td>62%</td>
<td>25%</td>
</tr>
</tbody>
</table>
- 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

---

**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
CPT Code: 93653

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 twice the 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac electrophysiology</td>
<td>25009</td>
<td>78.59 %</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5951</td>
<td>18.70 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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 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.
CPT Code: 93654

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
RUC Recommended RVU: 18.10

Global Period: 000
Current Work RVU: 19.75

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%

Percentage 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 health 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American College of Cardiology &amp; Heart Rhythm Society</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>93654</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1036</td>
</tr>
<tr>
<td>Resp N:</td>
<td>63</td>
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</tbody>
</table>

### Description of Sample:
Randomly selected electrophysiologists from the two societies.

### Service Performance Rate

<table>
<thead>
<tr>
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<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
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<td>20.00</td>
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### Survey RVW:

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<th>Median*</th>
<th>75th pctl</th>
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<td>9.50</td>
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<td>29.71</td>
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### Pre-Service Evaluation Time:

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<th>Median*</th>
<th>75th pctl</th>
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### Pre-Service Positioning Time:

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<th>Median*</th>
<th>75th pctl</th>
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</thead>
<tbody>
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<td>15.00</td>
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</tbody>
</table>

### Pre-Service Scrub, Dress, Wait Time:

<table>
<thead>
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<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00</td>
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<td></td>
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</table>

### Intra-Service Time:

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
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<td>17.00</td>
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### Immediate Post Service-Time:

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<th>75th pctl</th>
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<tbody>
<tr>
<td>35.00</td>
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</tr>
</tbody>
</table>

### Post Operative Visits

**Physician standard total minutes per E/M visit:**
- 99291x (70)
- 99292x (30)
- 99231x (20)
- 99232x (40)
- 99233x (55)
- 99238x (20)
- 99239x (38)

### 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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93654</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong></td>
<td>18.10</td>
</tr>
</tbody>
</table>

### 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

### Immediate Post Service-Time:

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specialty Society Recommended Data**

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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93654</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong></td>
<td>18.10</td>
</tr>
</tbody>
</table>

### Adjustments/Recommended Post-Service Time

- **Immediate Post Service-Time:**
  - 33.00
  - 33.00
  - 0.00
<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93580</td>
<td>000</td>
<td>17.97</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93590</td>
<td>000</td>
<td>21.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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)

<table>
<thead>
<tr>
<th></th>
<th>Top Key Reference Code: 93654</th>
<th>Top Key Reference Code: 93580</th>
<th>2nd Key Reference Code: 93590</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>58.00</td>
<td>30.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>200.00</td>
<td>120.00</td>
<td>135.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>33.00</td>
<td>60.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>291.00</td>
<td>210.00</td>
<td>223.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>24%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>5%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>5%</td>
<td>24%</td>
<td>71%</td>
</tr>
</tbody>
</table>
CPT Code: 93654

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>10%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td></td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
<td>0%</td>
<td>15%</td>
<td>10%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Overall intensity/complexity

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>10%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>10%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>18%</td>
<td>85%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>15%</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>

### 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 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

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.
CPT Code: 93654

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

**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.
CPT Code: 93655

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
RUC Recommended RVU: 7.00

Global Period: ZZZ
Current Work RVU: 7.50

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, 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American College of Cardiology &amp; Heart Rhythm Society</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>93655</td>
</tr>
</tbody>
</table>

**Description of Sample:** randomly selected electrophysiologists from the two societies

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>11.00</td>
<td>25.00</td>
<td>50.00</td>
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<tr>
<td>Survey RVW:</td>
<td>3.28</td>
<td>7.00</td>
<td>8.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>14.00</td>
<td>45.00</td>
<td>60.00</td>
<td>69.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit:**
- 99291 (70)
- 99292 (30)
- 99231 (20)
- 99232 (40)
- 99233 (55)
- 99238(38)
- 99239 (55)
- 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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93655</th>
</tr>
</thead>
</table>

**Recommended Physician Work RVU:** 7.00

| Pre-Service Evaluation Time: | 0.00 |
| Pre-Service Positioning Time: | 0.00 |
| Pre-Service Scrub, Dress, Wait Time: | 0.00 |
| Intra-Service Time: | 60.00 |

**Immediate Post Service-Time:** 0.00

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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93655</th>
</tr>
</thead>
</table>

**Adjustments/Recommended Post-Service Time:** 0.00

**Specialty Recommended Post-Service Time:** 0.00

**Specialty Recommended Post Time Package:** 0.00

**ZZZ Global Code**
CPT Code: 93655

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>35306</td>
<td>ZZZ</td>
<td>9.25</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>37237</td>
<td>ZZZ</td>
<td>4.25</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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)**

<table>
<thead>
<tr>
<th>CPT Code: 93655</th>
<th>Top Key Reference CPT Code: 35306</th>
<th>2nd Key Reference CPT Code: 37237</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>60.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>53%</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

- Technical skill required
- Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>0%</td>
<td>71%</td>
<td>29%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>
- 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

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>54%</td>
<td>31%</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16%</td>
<td>31%</td>
<td>53%</td>
</tr>
</tbody>
</table>
- 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

---

### 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 volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the codes are
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac electrophysiology</td>
<td>25042</td>
<td>78.69 %</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5474</td>
<td>17.20 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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 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.
CPT Code: 93656

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
RUC Recommended RVU: 17.00

Global Period: 000 Current Work RVU: 19.77

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 transseptal 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 electrophysiological 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  
**CPT Code**: 93656  
**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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>30.00</td>
<td>60.00</td>
<td>100.00</td>
<td>214.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>8.85</td>
<td>17.00</td>
<td>21.50</td>
<td>28.48</td>
<td>46.00</td>
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</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>4.00</td>
<td>150.00</td>
<td>180.00</td>
<td>210.00</td>
<td>380.00</td>
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<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**  
**CPT Code and Number of Visits**

<table>
<thead>
<tr>
<th>Critical Care time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Other Hospital time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Discharge Day Mgmt:</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Office time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Prolonged Services:</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Sub Obs Care:</th>
<th>Total Min**</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
<td>99292x</td>
<td>0.00</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td>99231x</td>
<td>0.00</td>
<td>99232x</td>
<td>0.00</td>
<td>99233x</td>
<td>0.00</td>
<td>99217x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x</td>
<td>12x</td>
<td>0.00</td>
<td>13x</td>
<td>0.00</td>
<td>14x</td>
<td>0.00</td>
<td>15x</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
<td>55x</td>
<td>0.00</td>
<td>56x</td>
<td>0.00</td>
<td>57x</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
<td>99225x</td>
<td>0.00</td>
<td>99226x</td>
<td>0.00</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93656</th>
<th><strong>Recommended Physician Work RVU</strong>: 17.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>35.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>180.00</td>
<td></td>
</tr>
</tbody>
</table>

**Post-Service Time package**

**9B General Anes or Complex Regional Blk/Cmplx Proc**

| Immediate Post Service-Time: | 30.00 | 33.00 | -3.00 |

**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)
CPT Code: 93656

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93580</td>
<td>000</td>
<td>17.97</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93590</td>
<td>000</td>
<td>21.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

CPT Descriptor: 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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 93656</th>
<th>Top Key Reference CPT Code: 93580</th>
<th>2nd Key Reference CPT Code: 93590</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>63.00</td>
<td>30.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>210.00</td>
<td>120.00</td>
<td>135.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>33.00</td>
<td>60.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>306.00</td>
<td>210.00</td>
<td>223.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>0%</th>
<th>0%</th>
<th>17%</th>
<th>35%</th>
<th>48%</th>
</tr>
</thead>
</table>

#### 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>27%</td>
<td>73%</td>
<td></td>
</tr>
</tbody>
</table>

#### Technical Skill/Physical Effort

- Less
- Identical
- More

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>0%</th>
<th>5%</th>
<th>95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical effort required</td>
<td>10%</td>
<td>29%</td>
<td>59%</td>
</tr>
</tbody>
</table>
Psychological Stress

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>26%</td>
<td>70%</td>
</tr>
</tbody>
</table>

2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
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</thead>
<tbody>
<tr>
<td>Less</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td>More</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall intensity/complexity

| 0% | 12% | 23% | 65% |

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>18%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

Technical skill required

| 0% | 18% | 82% |

Physical effort required

| 0% | 29% | 71% |

Psychological Stress

- 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 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Electrophysiology</td>
<td>Commonly</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac electrophysiology</td>
<td>92256</td>
<td>86.50 %</td>
</tr>
<tr>
<td>Cardiology</td>
<td>13972</td>
<td>13.10 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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.
CPT Code: 93656

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

---

**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.
CPT Code: 93657

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93657  Tracking Number   Y5  Original Specialty Recommended RVU: 7.00
Global Period: ZZZ  Current Work RVU: 7.50  Presented Recommended RVU: 7.00
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American College of Cardiology &amp; Heart Rhythm Society</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>93657</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1036</td>
</tr>
<tr>
<td>Resp N:</td>
<td>61</td>
</tr>
<tr>
<td>Description of Sample:</td>
<td>electrophysiologists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>10.00</td>
<td>25.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>3.00</td>
<td>7.00</td>
<td>8.25</td>
<td>10.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>7.00</td>
<td>45.00</td>
<td>60.00</td>
<td>84.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Post Operative Visits

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>93657</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Recommended Pre-Service Time</td>
<td>0.00</td>
</tr>
<tr>
<td>Specialty Recommended Pre Time Package</td>
<td>0.00</td>
</tr>
<tr>
<td>Adjustments/Recommended Pre-Service Time</td>
<td>0.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>0.00</th>
<th>0.00</th>
<th>0.00</th>
</tr>
</thead>
</table>
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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>35306</td>
<td>ZZZ</td>
<td>9.25</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>37237</td>
<td>ZZZ</td>
<td>4.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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 coarctation), 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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9,013</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

Other Reference CPT Code

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZZ</td>
<td>8.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)
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.**

### TIME ESTIMATES (Median)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 93657</th>
<th>Top Key Reference CPT Code: 35306</th>
<th>2nd Key Reference CPT Code: 37237</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>90.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>60.00</td>
<td>90.00</td>
<td>47.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>35%</td>
<td>48%</td>
</tr>
</tbody>
</table>

#### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>10%</td>
<td>39%</td>
<td>61%</td>
</tr>
</tbody>
</table>
CPT Code: 93657

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>4%</td>
<td>26%</td>
<td>70%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Key Reference Code</th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>Less</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td>More</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>12%</td>
<td>24%</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0%</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUM 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 %
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 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.
Intracardiac echocardiography

Additional linear or focal

Percutaneous transcatheter

Thromboendarterectomy, intravascular stent(s) (except patch graft if included in procedure performed)

Percutaneous transcatheter closure of paravalvular leak; placement of an intracardiac catheter; catheterization, insertion and repositioning of multiple catheters (List separately in addition to code for primary procedure)

Intracardiac electrophysiologic evaluation with 3-dimensional mapping (List separately in addition to code for primary procedure)

Intracardiac catheter ablation of a discrete mechanism of induction of arrhythmia; with electrophysiologic evaluation during therapeutic/diagnostic intervention, including imaging
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
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).
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>93613</td>
<td>Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>5.23</td>
</tr>
</tbody>
</table>
CPT Code: 93613  Tracking Number
Original Specialty Recommended RVU: 5.23
Presented Recommended RVU: 5.23
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>01/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Richard Wright, MD; Mark Schoenfeld, MD; Thad Waites, MD; David Slotwiner, MD</td>
</tr>
<tr>
<td>Specialty(s):</td>
<td>ACC, HRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>93613</td>
</tr>
</tbody>
</table>

**Sample Size:** 500  
**Resp N:** 47  
**Response:** 9.4%

**Description of Sample:** random

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.00</td>
<td>50.00</td>
<td>100.00</td>
<td>128.00</td>
<td>250.00</td>
</tr>
</tbody>
</table>

| 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**

| 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 |

**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

| 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 |

**Immediate Post Service-Time:** 0.00

**Specialty Recommended Post-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 |

**Specialty Recommended Post Time Package**

| 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 |

**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 |

**Adjustments/Recommended Post-Service Time**

| Immediate Post Service-Time: | 0.00 | 0.00 | 0.00 |
CPT Code: 93613

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

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93609</td>
<td>ZZZ</td>
<td>4.99</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93655</td>
<td>ZZZ</td>
<td>7.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>57267</td>
<td>ZZZ</td>
<td>4.88</td>
<td>RUC Time</td>
<td>6,947</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>63048</td>
<td>ZZZ</td>
<td>3.47</td>
<td>RUC Time</td>
<td>134,208</td>
</tr>
</tbody>
</table>

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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>22851</td>
<td>ZZZ</td>
<td>6.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 93613</th>
<th>Top Key Reference CPT Code: 93609</th>
<th>2nd Key Reference CPT Code: 93655</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>90.00</td>
<td>90.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>90.00</td>
<td>90.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Mental Effort and Judgment (Mean)</th>
<th>Top Key Ref Code</th>
<th>2nd Key Ref Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0.88</td>
<td>0.62</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td>0.62</td>
<td>0.69</td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td>0.42</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort (Mean)

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Top Key Ref Code</th>
<th>2nd Key Ref Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.96</td>
<td>0.54</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Time Segment (Mean)</th>
<th>Top Key Ref Code</th>
<th>2nd Key Ref Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0.96</td>
<td>0.77</td>
</tr>
</tbody>
</table>

---

**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**
CPT Code: 93613

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty cardiac electrophysiology</td>
<td>Commonly</td>
</tr>
<tr>
<td>Specialty cardiology</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Specialty</td>
<td>How often?</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty cardiac electrophysiology</td>
<td>33654</td>
<td>66.43 %</td>
</tr>
<tr>
<td>Specialty cardiology</td>
<td>15500</td>
<td>30.59 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty cardiac electrophysiology</td>
<td>33654</td>
<td>66.43 %</td>
</tr>
<tr>
<td>Specialty cardiology</td>
<td>15500</td>
<td>30.59 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Survey Code: 93613</th>
<th># of Respondents: 47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey Code Descriptor: Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Ref Code: 93609</th>
<th># of Respondents: 26</th>
<th>% of Respondents: 55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Ref Code</th>
<th>Survey Code is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Intensity and Complexity:</td>
<td>Much Less</td>
</tr>
<tr>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment:</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis</td>
<td>0%</td>
<td>23%</td>
<td>77%</td>
</tr>
<tr>
<td>and/or number of management options that must be considered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>31%</td>
<td>43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill:</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>23%</td>
<td>77%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Effort:</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11%</td>
<td>35%</td>
<td>54%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress:</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suite with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>58%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>65%</td>
<td>23%</td>
</tr>
</tbody>
</table>
### ISSUE: EP 3D Mapping add-on

#### TAB: 24

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>DESC</th>
<th>Resp</th>
<th>MIN</th>
<th>25th</th>
<th>MED</th>
<th>75th</th>
<th>MAX</th>
<th>Time</th>
<th>EVAL</th>
<th>POSIT</th>
<th>SDW</th>
<th>MIN</th>
<th>25th</th>
<th>MED</th>
<th>75th</th>
<th>MAX</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>93609</td>
<td>Intraventricular and/or intra-atrial</td>
<td>26</td>
<td>0.055</td>
<td>4.99</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>93655</td>
<td>Intracardiac catheter ablation of</td>
<td>13</td>
<td>0.083</td>
<td>7.50</td>
<td>90</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CURRENT</td>
<td>93613</td>
<td>Intracardiac electrophysiologic</td>
<td>47</td>
<td>0.078</td>
<td>2.25</td>
<td>5.23</td>
<td>7.00</td>
<td>8.00</td>
<td>15.00</td>
<td>90</td>
<td>30</td>
<td>48</td>
<td>90</td>
<td>120</td>
<td>120</td>
<td>400</td>
<td></td>
<td></td>
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<td>0.058</td>
<td>5.23</td>
<td>90</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPC</td>
<td>57267</td>
<td>Insertion of mesh or other prost</td>
<td>0.108</td>
<td>4.88</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPC</td>
<td>63048</td>
<td>Laminectomy, facetectomy and</td>
<td>0.077</td>
<td>3.47</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMP</td>
<td>22851</td>
<td>Application of intervertebral bio</td>
<td>0.074</td>
<td>6.70</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.)

Signature

Mark Schoenfeld, MD, FHRS

Printed Signature

Heart Rhythm Society

Specialty Society

12/13/2016 Date
Attestation Statement

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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.)

____________________________________________
Signature

Richard Wright, MD
Printed Signature

__________________________________________
Specialty Society

_______________________________
Date

12/12/16
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:
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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
and takes significantly more mental effort and judgment than KRS code 92978, further supporting the recommended survey 25\textsuperscript{th} 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>93662</td>
<td>Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>2.53</td>
</tr>
</tbody>
</table>
CPT Code: 93662

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93662  Tracking Number: ZZZ  Original Specialty Recommended RVU: 2.53
Presented Recommended RVU: 2.53  RUC Recommended RVU: 2.53

Global Period: ZZZ  Current Work RVU: 2.80

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

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>43.00</td>
<td><strong>100.00</strong></td>
<td>120.00</td>
<td>250.00</td>
<td></td>
</tr>
</tbody>
</table>

**Survey RVW:** 1.80  
**Pre-Service Evaluation Time:** 0.00  
**Pre-Service Positioning Time:** 0.00  
**Pre-Service Scrub, Dress, Wait Time:** 0.00  
**Intra-Service Time:** 25.00

**Immediate Post Service-Time:** 0.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>CPT Code: 93662</th>
<th>Recommended Physician Work RVU: 2.53</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Pre-Service Time</strong></td>
<td><strong>Recommended Pre Time Package</strong></td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 0.00

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**

<table>
<thead>
<tr>
<th><strong>Recommended Post-Service Time</strong></th>
<th><strong>Recommended Post Time Package</strong></th>
<th><strong>Adjustments/Recommended Post-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
CPT Code: 93662

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x  0.00  99292x  0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x  0.00  99232x  0.00  99233x  0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x  0.00  99239x  0.00  99217x  0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x  0.00  12x  0.00  13x  0.00  14x  0.00  15x  0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x  0.00  55x  0.00  56x  0.00  57x  0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x  0.00  99225x  0.00  99226x  0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>92978</td>
<td>ZZZ</td>
<td>1.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93613</td>
<td>ZZZ</td>
<td>5.23</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36227</td>
<td>ZZZ</td>
<td>2.09</td>
<td>RUC Time</td>
<td>11,934</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36476</td>
<td>ZZZ</td>
<td>2.65</td>
<td>RUC Time</td>
<td>9,561</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>34713</td>
<td>ZZZ</td>
<td>2.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 93662

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.**

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 93662</th>
<th>Top Key Reference CPT Code: 92978</th>
<th>2nd Key Reference CPT Code: 93613</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>25.00</td>
<td>25.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>25.00</td>
<td>25.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>58%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>8%</td>
<td>25%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
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<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### 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.
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  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.
### INSTRUCTIONS

1. Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.
2. Hide columns and rows that do not contain data.
3. **1st REF** = Top Key Reference code data
4. **2nd REF** = Second Highest Key Reference code data
5. **CURRENT** = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.
6. **SVY** = Survey data - as it appears on the Summary of Recommendation form.
7. **REC** = Specialty Society recommended data as it appears on the Summary of Recommendation form.

#### ISSUE: Intracardiac Echocardiography (ICE)

#### TAB: 23

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>DESC</th>
<th>Resp</th>
<th>IWPUT</th>
<th>RVW</th>
<th>Total</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMD</th>
<th>SURVEY EXPERIENCE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MIN</td>
<td>25th</td>
<td>MED</td>
<td>75th</td>
<td>MAX</td>
<td>Time</td>
<td>EVAL</td>
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<tr>
<td>1st REF</td>
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<td>Endoluminal imaging of coronary artery</td>
<td>12</td>
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<td>25</td>
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<tr>
<td>2nd REF</td>
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<td>Intracardiac electrophysiology</td>
<td>10</td>
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<td>90</td>
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<tr>
<td>CURRENT</td>
<td>93662</td>
<td>Intracardiac echocardiography</td>
<td>42</td>
<td>0.152</td>
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<td>5.15</td>
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<td>Intracardiac echocardiography</td>
<td>42</td>
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<td>1.80</td>
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<td>REC</td>
<td>93662</td>
<td>Intracardiac echocardiography</td>
<td>42</td>
<td>0.152</td>
<td>1.80</td>
<td>5.15</td>
<td>8.25</td>
<td>25</td>
<td>7</td>
<td>20</td>
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<tr>
<td>MPC</td>
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<td>Selective catheter placement, ex</td>
<td>15</td>
<td>0.139</td>
<td>2.09</td>
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<tr>
<td>MPC</td>
<td>36476</td>
<td>Endovenous ablation therapy of</td>
<td>30</td>
<td>0.088</td>
<td>2.65</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td></td>
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<tr>
<td>COMP</td>
<td>34713</td>
<td>Percutaneous access and closure</td>
<td>20</td>
<td>0.125</td>
<td>2.50</td>
<td>20</td>
<td>20</td>
<td>20</td>
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<td></td>
</tr>
</tbody>
</table>
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
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 25\textsuperscript{th} 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 /
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.
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.
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>93621</td>
<td>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)</td>
<td>ZZZ</td>
<td>1.75</td>
</tr>
</tbody>
</table>
CPT Code: 93621

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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Richard Wright, MD, Thad Waites, MD and Christopher Liu, MD, David Slotwiner, MD, Mark Schoenfeld, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American College of Cardiology; Heart &amp; Rhythm Society</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>93621</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1188</td>
</tr>
<tr>
<td>Resp N:</td>
<td>53</td>
</tr>
</tbody>
</table>

**Description of Sample:** random ACC electrophysiologist members and random HRS members

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>1.45</td>
<td>2.50</td>
<td>3.20</td>
<td>5.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>12.00</td>
<td>20.00</td>
<td>35.00</td>
<td>200.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

| Critical Care time/visit(s): | 99291x | 0.00 | 99292x | 0.00 |
| Other Hospital time/visit(s): | 99231x | 0.00 | 99232x | 0.00 | 99233x | 0.00 |
| Discharge Day Mgmt: | 99238x | 0.00 | 99239x | 0.00 | 99217x | 0.00 |
| Office time/visit(s): | 99211x | 0.00 | 12x | 0.00 | 13x | 0.00 | 14x | 0.00 | 15x | 0.00 |
| Prolonged Services: | 99354x | 0.00 | 55x | 0.00 | 56x | 0.00 | 57x | 0.00 |
| Sub Obs Care: | 99224x | 0.00 | 99225x | 0.00 | 99226x | 0.00 |

**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)

| CPT Code: | 93621 |
| Recommended Physician Work RVU: | 1.75 |

| 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 |

**Immediate Post Service-Time:**

| CPT Code: | 93621 |
| Recommended Physician Work RVU: | 1.75 |

| 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: | 0.00 | 0.00 | 0.00 |

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 Pre-Service Time**
- **Recommended Pre Time Package**
- **Adjustments/Recommended Pre-Service Time**

**Specialty**

- **Recommended Post-Service Time**
- **Recommended Post Time Package**
- **Adjustments/Recommended Post-Service Time**

**Immediate Post Service-Time:**

- **Recommended Post-Service Time**
- **Recommended Post Time Package**
- **Adjustments/Recommended Post-Service Time**
## CPT Code: 93621

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93609</td>
<td>ZZZ</td>
<td>4.99</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99292</td>
<td>ZZZ</td>
<td>2.25</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36227</td>
<td>ZZZ</td>
<td>2.09</td>
<td>RUC Time</td>
<td>12,831</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37253</td>
<td>ZZZ</td>
<td>1.44</td>
<td>RUC Time</td>
<td>65,235</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>36483</td>
<td>ZZZ</td>
<td>1.75</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 93621

CPT Descriptor: Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., 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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 93621</th>
<th>Top Key Reference CPT Code: 93609</th>
<th>2nd Key Reference CPT Code: 99292</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>20.00</td>
<td>90.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>20.00</td>
<td>90.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>28%</td>
<td>28%</td>
<td>22%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>22%</td>
<td>28%</td>
<td>50%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 93621

- Urgency of medical decision making

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>11%</td>
<td>50%</td>
<td>39%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>22%</td>
<td>44%</td>
<td>34%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>28%</td>
<td>39%</td>
<td>33%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>2nd Key Reference Code</th>
<th>Much</th>
<th>Less</th>
<th>Identical</th>
<th>Somewhat</th>
<th>More</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>17%</td>
<td>83%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>17%</td>
<td>83%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
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<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
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<tr>
<td>Outcome depends on the skill and judgment of physician</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Commonly</td>
</tr>
<tr>
<td>HRS</td>
<td>Commonly</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Electrophysiology</td>
<td>48000</td>
<td>80.28 %</td>
</tr>
<tr>
<td>Cardiology</td>
<td>11794</td>
<td>19.72 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
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<td>0</td>
<td>0.00 %</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Electrophysiology</td>
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<td>80.28 %</td>
</tr>
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<td>Cardiology</td>
<td>5892</td>
<td>19.71 %</td>
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<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
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<td>0.00 %</td>
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</table>

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.
ISSUE: Electrophysiological services

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>Resp</th>
<th>INPUT</th>
<th>RVW</th>
<th>Total</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMD</th>
<th>SURVEY EXPERIENCE</th>
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<tbody>
<tr>
<td>1st REF</td>
<td>93609</td>
<td>ZZZ</td>
<td>Intraventricular and/or intratricular mapping of tachycardia</td>
<td>18</td>
<td>0.055</td>
<td>4.99</td>
<td>90</td>
<td>0 0 0 0 90</td>
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<tr>
<td>2nd REF</td>
<td>99292</td>
<td>ZZZ</td>
<td>Critical care, evaluation and management of the critically ill</td>
<td>6</td>
<td>0.075</td>
<td>2.25</td>
<td>30</td>
<td>0 0 0 0 30</td>
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<td>CURRENT</td>
<td>93621</td>
<td>ZZZ</td>
<td>Comprehensive electrophysiologic evaluation</td>
<td>0.070</td>
<td>2.10</td>
<td>30</td>
<td>30</td>
<td>0 0 0 0 30</td>
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<td>SVY</td>
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<td>ZZZ</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple</td>
<td>53</td>
<td>0.160</td>
<td>1.45</td>
<td>3.20</td>
<td>5.00 20.00</td>
<td>0 0 0 5 12 20 35 200</td>
<td>0 0 40 75 120 250</td>
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<tr>
<td>REC</td>
<td>93621</td>
<td>ZZZ</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple</td>
<td>0.088</td>
<td>1.75</td>
<td>20</td>
<td>0 0 0 0 20</td>
<td>0</td>
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<td>COMP</td>
<td>37252</td>
<td>ZZZ</td>
<td>Intravascular ultrasound (noncoronary vessel) during</td>
<td>0.088</td>
<td>1.80</td>
<td>22</td>
<td>1 0 0 0 22</td>
<td>1</td>
<td></td>
<td></td>
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<td>COMP</td>
<td>20931</td>
<td>ZZZ</td>
<td>Allograft, structural, for spine surgery only (List separately in</td>
<td>0.091</td>
<td>1.81</td>
<td>20</td>
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<td>COMP</td>
<td>15151</td>
<td>ZZZ</td>
<td>Tissue cultured skin autograft, trunk, arms, legs, additional 1</td>
<td>0.100</td>
<td>2.00</td>
<td>20</td>
<td>0 0 0 0 20</td>
<td>0</td>
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<tr>
<td>COMP</td>
<td>36483</td>
<td>ZZZ</td>
<td>Endovenous ablation therapy of incompetent vein, extremity.</td>
<td>0.088</td>
<td>1.75</td>
<td>20</td>
<td>0 0 0 0 20</td>
<td>0</td>
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<td></td>
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<tr>
<td>MPC</td>
<td>37253</td>
<td>ZZZ</td>
<td>Intravascular ultrasound (noncoronary vessel) during</td>
<td>0.071</td>
<td>1.44</td>
<td>21</td>
<td>0 0 0 0 21</td>
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<td>MPC</td>
<td>36227</td>
<td>ZZZ</td>
<td>Selective catheter placement, external carotid artery.</td>
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<td>2.09</td>
<td>15</td>
<td>0 0 0 0 15</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
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 (43X21 or 43X22). 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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43X21 *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 43X21 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 43X21 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 43X21 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 43X21.**

43X22 *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 43X22 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 43X22 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 43X22 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 43X22.**

**Practice Expense**
For CPT code 43X21, 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 43X21 and 43X22 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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
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<td>43197</td>
<td></td>
<td><em>Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</em></td>
<td>000</td>
<td>2.09 (No change)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 43197 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43198, 43X21, 43200-43232, 43235-43259, 43266, 43270, 434XX, 92511, 05X2T, 05X3T, 05X7T)</td>
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<td></td>
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<td>(Do not report 43197 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)</td>
<td></td>
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</tr>
<tr>
<td></td>
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<td>(For transoral esophagoscopy, see 43191, 43200)</td>
<td></td>
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</tr>
<tr>
<td>43198</td>
<td></td>
<td><em>with biopsy, single or multiple</em></td>
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<td>(Do not report 43198 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43197, 43X21, 43200-43232, 43235-43259, 43266, 43270, 92511, 05X2T, 05X3T, 05X7T)</td>
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<td>(Do not report 43198 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)</td>
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<td>(For transoral esophagoscopy with biopsy, see 43193, 43202)</td>
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</tbody>
</table>

**Esophagogastroduodenoscopy**

<p>| (f)43235 | B1      | <em>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</em> | 000           | 2.09 (No change) |
|          |         | (Do not report 43235 in conjunction with 43197, 43198, 43X21, 43210, 43236-43259, 43266, 43270, 434XX, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379) |               |                          |</p>
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<th>Code</th>
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<tr>
<td>43241</td>
<td>with insertion of intraluminal tube or catheter</td>
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<td>44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379)</td>
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<td>43247</td>
<td>with removal of foreign body(s)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If fluoroscopic guidance is performed, use 76000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43X21</td>
<td>with deployment of intragastric bariatric balloon</td>
<td></td>
<td>000</td>
</tr>
<tr>
<td></td>
<td>(Do not report 43X21 in conjunction with 43197, 43198, 43235, 43241, 43247)</td>
<td></td>
<td>3.11</td>
</tr>
<tr>
<td>43X22</td>
<td>with removal of intragastric bariatric balloon(s)</td>
<td></td>
<td>000</td>
</tr>
<tr>
<td></td>
<td>(Do not report 43X22 in conjunction with 43197, 43198, 43235, 43247)</td>
<td></td>
<td>2.80</td>
</tr>
<tr>
<td>43248</td>
<td>with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Do not report 43248 in conjunction with 43197, 43198, 43235, 43266, 43270, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44372, 44373, 44376, 44377, 44378, 44379)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If fluoroscopic guidance is performed, use 74360)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 43235

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43235  Tracking Number: B1  Original Specialty Recommended RVU: 2.09
Global Period: 000  Current Work RVU: 2.09  Presented Recommended 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

### CPT Code: 43235

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>43235</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2328</td>
</tr>
<tr>
<td>Resp N:</td>
<td>54</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>1.50</td>
<td>2.10</td>
<td>2.25</td>
<td>2.50</td>
<td>4.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>14.00</td>
<td>13.00</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>1.00</td>
<td>2.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>5.00</td>
<td>6.00</td>
<td>-1.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit:**
- 99291x (70)
- 99292x (30)
- 99231x (20)
- 99232x (40)
- 99233x (55)
- 99238x (38)
- 99239x (55)
- 99217x (15)
- 99211x (7)
- 99212x (16)
- 99213x (23)
- 99214x (40)
- 99215x (55)
- 99224x (20)
- 99225x (40)
- 99226x (55)
- 99354x (60)
- 99355x (30)
- 99356x (60)
- 99357x (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 Straightforward Pat/Procedure (no sedate/anesth)

**Recommended Physician Work RVU:** 2.09

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>43235</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong></td>
<td>2.09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre-Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>14.00</td>
<td>13.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>5.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>15.00</td>
<td></td>
</tr>
</tbody>
</table>

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
CPT Code: 43235

<table>
<thead>
<tr>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>12.00</td>
<td>-13.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43202</td>
<td>000</td>
<td>1.72</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Esophagoscopy, flexible, transoral; with biopsy, single or multiple

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43216</td>
<td>000</td>
<td>2.30</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>64483</td>
<td>000</td>
<td>1.90</td>
<td>RUC Time</td>
<td>1,044,547</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Injection(s), anesthetic agent(s) and/or steroid; transperitoneal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>64479</td>
<td>000</td>
<td>2.29</td>
<td>RUC Time</td>
<td>44,367</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: Injection(s), anesthetic agent(s) and/or steroid; transperitoneal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level

Other Reference CPT Code | Global | Work RVU | Time Source   |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 43235</th>
<th>Top Key Reference CPT Code: 43202</th>
<th>2nd Key Reference CPT Code: 43216</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>22.00</td>
<td>22.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>15.00</td>
<td>15.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>12.00</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>49.00</td>
<td>47.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>50%</td>
<td>46%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

Less | Identical | More
--- | -------- | ---
8%   | 54%     | 38%
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>54%</td>
<td>42%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>4%</td>
<td>62%</td>
<td>34%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>4%</td>
<td>73%</td>
<td>23%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>20%</td>
<td>20%</td>
<td>60%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. If your society has used an IPWPUT 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, 43X21 and 43X22.

- **43235** Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- **43X21** with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance
- **43X22** with removal of intragastric bariatric balloon(s)

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43X21 and 43X22 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, 43X21 and 43X22, 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:**
The table below pertains to the next section on SERVICES REPORTED WITH MULTIPLE CPT CODES:
EGD (43235) with moderate sedation provided by same physician

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic surgeon</td>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
<td>2.80</td>
<td>26</td>
<td>30</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic surgeon</td>
<td>99152</td>
<td>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</td>
<td>XXX</td>
<td>0.25</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic surgeon</td>
<td>99153</td>
<td>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)</td>
<td>XXX</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No</td>
</tr>
</tbody>
</table>

EGD (43235) with anesthesia

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic surgeon</td>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
<td>2.80</td>
<td>26</td>
<td>30</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia professional</td>
<td>00731</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified</td>
<td>XXX</td>
<td>5.00</td>
<td>19</td>
<td>25</td>
<td>10</td>
<td>No</td>
</tr>
</tbody>
</table>

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.
   - [x] 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

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

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.
CPT Code: 43X21

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43X21  Tracking Number: B2  Original Specialty Recommended RVU: 3.40
Global Period: 000  Current Work RVU: 3.11
Presented Recommended RVU: 3.11  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
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>43X21</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2328</td>
</tr>
<tr>
<td>Resp N:</td>
<td>51</td>
</tr>
</tbody>
</table>

**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 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

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>5.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>2.20</td>
<td>3.40</td>
<td>3.50</td>
<td>4.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>7.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>6.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>30.00</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 20.00

**Post Operative 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 |

**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)**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>43X21</th>
<th>Recommended Physician Work RVU: 3.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>18.00</td>
<td>18.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>5.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td></td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20.00</td>
<td>25.00</td>
<td>50.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43212</td>
<td>000</td>
<td>3.40</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43226</td>
<td>000</td>
<td>2.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>10030</td>
<td>000</td>
<td>2.75</td>
<td>RUC Time</td>
<td>8,525</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37191</td>
<td>000</td>
<td>4.46</td>
<td>RUC Time</td>
<td>25,555</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 43X21</th>
<th>Top Key Reference CPT Code: 43212</th>
<th>2nd Key Reference CPT Code: 43226</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>26.00</td>
<td>26.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>25.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>20.00</td>
<td>20.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>76.00</td>
<td>76.00</td>
<td>57.00</td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>760</td>
<td>0%</td>
<td>19%</td>
<td>28%</td>
<td>53%</td>
</tr>
</tbody>
</table>
### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>19%</td>
<td>78%</td>
</tr>
</tbody>
</table>

- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>

- Technical skill required
- Physical effort required

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>16%</td>
<td>81%</td>
</tr>
</tbody>
</table>

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of the physician
- Estimated risk of malpractice suit with poor outcome

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

- Technical skill required
- Physical effort required

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>16%</td>
<td>84%</td>
</tr>
</tbody>
</table>

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of the physician
- Estimated risk of malpractice suit with poor outcome
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, 43X21 and 43X22.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
</tr>
<tr>
<td>43X21</td>
<td>with deployment of intragastric bariatric balloon</td>
</tr>
<tr>
<td>43X22</td>
<td>with removal of intragastric bariatric balloon(s)</td>
</tr>
</tbody>
</table>

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43X21 and 43X22 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, 43X21 and 43X22, comparing the data and work RVUs (wRVUs) to the current data for similar 000-day global codes that were recently approved by the RUC.

43X21 – Discussion and Recommendation
Code 43X21 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.

43X21 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.
CPT Code: 43X21

### Detailed Description of Pre-Service Time Packages (Minutes)

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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).

**43X21 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 43X21 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.
We also note that the 3.40 wRVU recommendation for 43X21 fits appropriately within the EGD family, which additionally validates the survey 25th percentile wRVU (see the table below).
### Table 1: CPT Code Crosswalks

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Desc</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre Time</th>
<th>Pre Eval</th>
<th>Pre Position</th>
<th>Pre Scrub, Dress, Wait</th>
<th>Intra</th>
<th>Immed Post</th>
<th>Total Time</th>
<th>Time Source</th>
<th>Most Recent RUC Review</th>
<th>IMPUT</th>
<th>2019 Medicare UDL</th>
</tr>
</thead>
<tbody>
<tr>
<td>43212</td>
<td>Esophagogastroduodenoscopy, flexible, transoral</td>
<td>000.67</td>
<td>2.34</td>
<td>14</td>
<td>3.0</td>
<td>5.0</td>
<td>20</td>
<td>15</td>
<td>57</td>
<td>RUC 2013-01</td>
<td>0.082</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43213</td>
<td>Esophagogastroduodenoscopy, flexible, transoral</td>
<td>000.67</td>
<td>2.34</td>
<td>14</td>
<td>3.0</td>
<td>5.0</td>
<td>20</td>
<td>15</td>
<td>57</td>
<td>RUC 2013-01</td>
<td>0.082</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43214</td>
<td>Esophagogastroduodenoscopy, flexible, transoral</td>
<td>000.67</td>
<td>2.34</td>
<td>14</td>
<td>3.0</td>
<td>5.0</td>
<td>20</td>
<td>15</td>
<td>57</td>
<td>RUC 2013-01</td>
<td>0.082</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43215</td>
<td>Esophagogastroduodenoscopy, flexible, transoral</td>
<td>000.67</td>
<td>2.34</td>
<td>14</td>
<td>3.0</td>
<td>5.0</td>
<td>20</td>
<td>15</td>
<td>57</td>
<td>RUC 2013-01</td>
<td>0.082</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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

### Table 2: Additional CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Desc</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre Time</th>
<th>Pre Eval</th>
<th>Pre Position</th>
<th>Pre SDw</th>
<th>Intra</th>
<th>Immed Post</th>
<th>Total Time</th>
<th>Time Source</th>
<th>Most Recent RUC Review</th>
<th>IMPUT</th>
<th>2019 Medicare UDL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5134</td>
<td>Cystoscopy with insertion of ureteral guide wire</td>
<td>000.87</td>
<td>1.38</td>
<td>18</td>
<td>6.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>70</td>
<td>RUC 2018-03</td>
<td>0.0816</td>
<td>189</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5086</td>
<td>Biopsy, breast, with placement of breast localization</td>
<td>000.79</td>
<td>1.25</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2013-04</td>
<td>0.0849</td>
<td>60561</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5257</td>
<td>Nasal/sinus endoscopy, with maxillary antrostomy</td>
<td>000.72</td>
<td>1.10</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2012-10</td>
<td>0.0792</td>
<td>86244</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5176</td>
<td>Nonsurgical endoscopy, with maxillary antrostomy</td>
<td>000.71</td>
<td>1.00</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2017-01</td>
<td>0.0759</td>
<td>7592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5374</td>
<td>Nasal/sinus endoscopy, with intranasal stent</td>
<td>000.79</td>
<td>1.25</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2017-01</td>
<td>0.074</td>
<td>22234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5267</td>
<td>Perforation of nasal septum</td>
<td>000.70</td>
<td>1.00</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2017-01</td>
<td>0.0759</td>
<td>7592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3997</td>
<td>Removal of nasal septum</td>
<td>000.70</td>
<td>1.00</td>
<td>13</td>
<td>3.0</td>
<td>6.0</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>RUC 2017-01</td>
<td>0.0759</td>
<td>7592</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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).

---

CPT Code 43X21

## Codes

Codes 19081 and 52334 are candidates for potential crosswalk if the RUC is uncomfortable with the 43X21 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 43X22 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 43X21 to demonstrate how each would fit within the context of the EGD family.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Desc</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre Time</th>
<th>Pre Eval Time</th>
<th>Pre Position Time</th>
<th>Pre Scrub, Dress, Wait Time</th>
<th>Immed Pre Time</th>
<th>Intra Time</th>
<th>Total Time</th>
<th>Source</th>
<th>Most Recent RUC Review</th>
<th>RUC-CMS</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2017-01</td>
<td>0.069</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19081</td>
<td>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;</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.085</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52334</td>
<td>Other potential Xwalk for 43X21 - Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2018-01</td>
<td>0.082</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43X21</td>
<td>w/ balloon placement (25th percentile RVU)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2015-04</td>
<td>0.081</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43237</td>
<td>w/ EUS scope w/ adj snare</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.071</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43251</td>
<td>w/ removal tumor polyp/other lesion snare tech</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.140</td>
<td></td>
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</tr>
<tr>
<td>43246</td>
<td>w/ g-tube placement</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.087</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43255</td>
<td>w/ control of bleeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.083</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43266</td>
<td>w/ stent placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.071</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43270</td>
<td>w/ ablate tumor polyp/lesion w/ dilation &amp; wire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.068</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43259</td>
<td>w/ EUS exam surgical alter stom duodenum/jejunum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.066</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43233</td>
<td>w/ esophagus balloon dilation 33mm or larger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43257</td>
<td>w/ deliver thermal energy sphincter/cardia GERD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.071</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43238</td>
<td>w/ intrmural US needle aspirate/biopsy esophagus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.070</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43243</td>
<td>w/ injection sclerosis esoph/gastric varices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43244</td>
<td>w/ band ligation esophageal/gastric varices</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43242</td>
<td>w/ intrmural needle aspir/biop altered anatomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.072</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43253</td>
<td>w/ EUS guided transmural injxn/liducial marker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43254</td>
<td>w/ EMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-01</td>
<td>0.086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43240</td>
<td>w/ transoral transmural drainage pseudocyst</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC 2013-04</td>
<td>0.084</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43210</td>
<td>w/ partial/compl esophagogastroduodenoplasty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RUC-CMF 2015-04</td>
<td>0.100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 43X21 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

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU / Base Unit</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic</td>
<td>43X21</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance</td>
<td>000</td>
<td>3.40 wRVU</td>
<td>26</td>
<td>30</td>
<td>20</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic</td>
<td>99152</td>
<td>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</td>
<td>XXX</td>
<td>0.25 wRVU</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic</td>
<td>99153</td>
<td>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)</td>
<td>XXX</td>
<td>0.00 wRVU</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No</td>
</tr>
</tbody>
</table>

## Balloon placement (43X21) with anesthesia

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU / Base Unit</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic</td>
<td>43X21</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance</td>
<td>000</td>
<td>3.40 wRVU</td>
<td>26</td>
<td>30</td>
<td>20</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia professional</td>
<td>00731</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified</td>
<td>XXX</td>
<td>5 base units</td>
<td>19</td>
<td>25</td>
<td>10</td>
<td>No</td>
</tr>
</tbody>
</table>

---

### 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.
   - [x] 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. 43X21 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 43X21. No multiple procedures reduction policies
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

<table>
<thead>
<tr>
<th>Specialty Gastroenterology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5300</td>
<td>70.00 %</td>
<td></td>
</tr>
<tr>
<td>Specialty General Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>2272</td>
<td>30.00 %</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.00 %</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Specialty Gastroenterology</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1767</td>
<td>70.03 %</td>
<td></td>
</tr>
<tr>
<td>Specialty General Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>757</td>
<td>30.00 %</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.00 %</td>
<td></td>
</tr>
</tbody>
</table>

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
CPT Code: 43X22

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43X22 Tracking Number B3 Original Specialty Recommended RVU: 2.80
Global Period: 000 Current Work RVU: Presented Recommended RVU: 2.80
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)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of survey respondents who stated they perform the procedure; In the hospital</td>
<td>0%</td>
</tr>
<tr>
<td>In the ASC</td>
<td>0%</td>
</tr>
<tr>
<td>In the office</td>
<td>0%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;</td>
<td></td>
</tr>
<tr>
<td>Discharged the same day</td>
<td>0%</td>
</tr>
<tr>
<td>Overnight stay-less than 24 hours</td>
<td>0%</td>
</tr>
<tr>
<td>Overnight stay-more than 24 hours</td>
<td>0%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day</td>
<td>0%</td>
</tr>
</tbody>
</table>

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 reinsufflated. 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>R. Bruce Cameron, MD (ACG); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Ketan Sheth, MD (SAGES)</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of American Gastrointestinal and Endoscopic Surgeons</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>43X22</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>2328</td>
</tr>
<tr>
<td><strong>Resp N:</strong></td>
<td>51</td>
</tr>
</tbody>
</table>

**Description of Sample:** The ACG, AGA and ASGE surveyed a random sample of 1,000 members; with email bouncesbacks, 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 bouncesbacks, 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

**Service Performance Rate**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>5.00</td>
<td>14.00</td>
<td>200.00</td>
</tr>
</tbody>
</table>

**Survey RVW:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.44</td>
<td>2.80</td>
<td>3.50</td>
<td>3.84</td>
<td>10.50</td>
</tr>
</tbody>
</table>

**Pre-Service Evaluation Time:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.44</td>
<td>2.80</td>
<td>3.50</td>
<td>3.84</td>
<td>10.50</td>
</tr>
</tbody>
</table>

**Pre-Service Positioning Time:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>1.00</td>
<td>2.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pre-Service Scrub, Dress, Wait Time:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intra-Service Time:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.00</td>
<td>20.00</td>
<td>30.00</td>
<td>35.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:**

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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:** 43X22  
**Recommended Physician Work RVU:** 2.80

<table>
<thead>
<tr>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.00</td>
<td>18.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>18.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>5.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td>-1.00</td>
</tr>
</tbody>
</table>

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 Blnk/Strghtforw Proc

**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)
<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43215</td>
<td>000</td>
<td>2.44</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Esophagoscopy, flexible, transoral; with removal of foreign body(s)

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43212</td>
<td>000</td>
<td>3.40</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>31622</td>
<td>000</td>
<td>2.53</td>
<td>RUC Time</td>
<td>6,254,698</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37191</td>
<td>000</td>
<td>4.46</td>
<td>RUC Time</td>
<td>6,976,757</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>4.46</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT Code: 43X22</th>
<th>Top Key Reference CPT Code: 43215</th>
<th>2nd Key Reference CPT Code: 43212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>26.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>71.00</td>
<td>53.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
<td>46%</td>
<td>43%</td>
</tr>
<tr>
<td>Mental Effort and Judgment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>18%</td>
<td>82%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>4%</td>
<td>11%</td>
<td>85%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>14%</td>
<td>86%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>8%</td>
<td>17%</td>
<td>42%</td>
<td>33%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8%</td>
<td>17%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
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<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8%</td>
<td>8%</td>
<td>84%</td>
</tr>
</tbody>
</table>

## 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, 43X21 and 43X22.

- **43235**: Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- **43X21**: with deployment of intragastric bariatric balloon
- **43X22**: with removal of intragastric bariatric balloon(s)

The Research Subcommittee approved our proposed survey methodology to survey codes 43235, 43X21 and 43X22 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, 43X21 and 43X22, comparing the data and work RVUs (wRVUs) to the current data for similar 000-day global codes that were recently approved by the RUC.

**43X22 – Discussion and Recommendation**

Code 43X22 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)

<table>
<thead>
<tr>
<th>FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CATEGORY SUBTOTALS</th>
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</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
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<td>A</td>
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<tr>
<td>A</td>
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</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>C</td>
</tr>
</tbody>
</table>

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:
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>43X22</td>
<td>Esophagogastrod...</td>
<td>2.80</td>
<td>2.80</td>
<td>18</td>
<td>3</td>
<td>5</td>
<td>30</td>
<td>15</td>
<td>71</td>
<td>2014-10</td>
<td>GASTROENTEROLOGY</td>
<td>0.0693</td>
<td>4580</td>
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</tr>
</tbody>
</table>

### Aorta and Peripheral Artery Procedures

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<thead>
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<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43X22</td>
<td>Esophagogastrod...</td>
<td>2.80</td>
<td>2.80</td>
<td>18</td>
<td>3</td>
<td>5</td>
<td>30</td>
<td>15</td>
<td>71</td>
<td>2014-10</td>
<td>GASTROENTEROLOGY</td>
<td>0.0693</td>
<td>4580</td>
<td></td>
</tr>
</tbody>
</table>

### Conclusion

The document contains a comprehensive list of procedures coded under CPT Code 43X22, which includes various endoscopic and interventional procedures. The table format provides detailed information on each procedure, including its description, global work, and associated RVUs and Medicare code numbers. This information is crucial for healthcare providers and administrators in understanding the scope and cost implications of these procedures in the context of the EGD family of codes. The inclusion of recent Medicare utilization data allows for a comparative analysis of how these services are utilized across different specialties and institutions.

---

**43X22 comparison to codes in the EGD family**

The document details the CPT Code 43X22 and its application to endoscopic procedures, providing a thorough comparison to the broader family of EGD codes. This comparison highlights the specific subset of procedures covered by 43X22, along with detailed RVU and Medicare code information. The table structure ensures clarity and ease of understanding, facilitating informed decision-making in healthcare settings.
### Balloon removal (43X22) with moderate sedation provided by same physician

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic surgeon</td>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
<td>2.80</td>
<td>26</td>
<td>30</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic surgeon</td>
<td>99152</td>
<td>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 intra-service time, patient age 5 years or older</td>
<td>XXX</td>
<td>0.25</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>GI or endoscopic surgeon</td>
<td>99153</td>
<td>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 intra-service time (List separately in addition to code for primary service)</td>
<td>XXX</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No</td>
</tr>
</tbody>
</table>

### Balloon removal (43X22) with anesthesia

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPT</th>
<th>Description</th>
<th>Global</th>
<th>wRVU</th>
<th>Pre-service time</th>
<th>Intra-service time</th>
<th>Post-service time</th>
<th>Overlapping procedure work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI or endoscopic surgeon</td>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
<td>2.80</td>
<td>26</td>
<td>30</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia professional</td>
<td>00731</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified</td>
<td>XXX</td>
<td>5.00</td>
<td>19</td>
<td>25</td>
<td>10</td>
<td>No</td>
</tr>
</tbody>
</table>
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. 43X22 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 43X22. No multiple procedures reduction policies apply. See SOR 43X22 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

Estimate the number of times this service might be provided nationally in a one-year period? 7,571
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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Gastroenterology</td>
<td>5300</td>
<td>70.00 %</td>
</tr>
<tr>
<td>Specialty General Surgery</td>
<td>2272</td>
<td>30.00 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Gastroenterology</td>
<td>1767</td>
<td>70.03 %</td>
</tr>
</tbody>
</table>
CPT Code: 43X22

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
<table>
<thead>
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<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
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<th>Resp</th>
<th>WPUT</th>
<th>Work Per Unit Time</th>
<th>RVV</th>
<th>Total</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMD</th>
<th>SURVEY EXPERIENCE</th>
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<td></td>
</tr>
<tr>
<td>1st REF</td>
<td>43202</td>
<td>000</td>
<td>Esophagoscopy, flexible, transoral; with biopsy, single or multiple</td>
<td>2012</td>
<td>26</td>
<td>0.072</td>
<td>0.037</td>
<td>1.72</td>
<td>47</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>2nd REF</td>
<td>43216</td>
<td>000</td>
<td>Esophagoscopy, flexible, transoral; with removal of tumor(s), poly(s), or other lesion(s) by hot biopsy forceps</td>
<td>2012</td>
<td>5</td>
<td>0.074</td>
<td>0.042</td>
<td>2.30</td>
<td>55</td>
<td>15</td>
<td>3</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>CURRENT</td>
<td>43235</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>2013</td>
<td>0.093</td>
<td>0.043</td>
<td>2.09</td>
<td>49</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>SVY - all data</td>
<td>43235</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td></td>
<td>54</td>
<td>0.086</td>
<td>0.037</td>
<td>1.50</td>
<td>2.10</td>
<td>2.50</td>
<td>4.00</td>
<td>61</td>
<td>23</td>
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<tr>
<td>REC</td>
<td>43235</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td></td>
<td>0.093</td>
<td>0.043</td>
<td>2.09</td>
<td>49</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>1st REF</td>
<td>43212</td>
<td>000</td>
<td>Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>2013</td>
<td>32</td>
<td>0.081</td>
<td>0.045</td>
<td>3.40</td>
<td>76</td>
<td>23</td>
<td>3</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>2nd REF</td>
<td>43226</td>
<td>000</td>
<td>Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire</td>
<td>2012</td>
<td>6</td>
<td>0.064</td>
<td>0.039</td>
<td>2.24</td>
<td>57</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>SVY - all data</td>
<td>43X21</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon</td>
<td></td>
<td>51</td>
<td>0.065</td>
<td>0.034</td>
<td>2.20</td>
<td>3.40</td>
<td>3.50</td>
<td>4.00</td>
<td>8.82</td>
<td>103</td>
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<td>Xwalk</td>
<td>31256</td>
<td>000</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy</td>
<td>2017</td>
<td>0.069</td>
<td>0.037</td>
<td>3.11</td>
<td>83</td>
<td>15</td>
<td>8</td>
<td>10</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>REC</td>
<td>43X21</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of gastric bariatric device (eg, balloon) under endoscopic guidance</td>
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<td>0.072</td>
<td>0.041</td>
<td>3.11</td>
<td>76</td>
<td>18</td>
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<td>5</td>
<td>30</td>
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<tr>
<td>1st REF</td>
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<td>000</td>
<td>Esophagoscopy, flexible, transoral; with removal of foreign body(s)</td>
<td>2012</td>
<td>28</td>
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<td>0.046</td>
<td>2.44</td>
<td>53</td>
<td>15</td>
<td>3</td>
<td>5</td>
<td>20</td>
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<tr>
<td>2nd REF</td>
<td>43212</td>
<td>000</td>
<td>Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>2013</td>
<td>12</td>
<td>0.081</td>
<td>0.045</td>
<td>3.40</td>
<td>76</td>
<td>23</td>
<td>3</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>SVY - all data</td>
<td>43X22</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td></td>
<td>51</td>
<td>0.073</td>
<td>0.038</td>
<td>2.44</td>
<td>2.80</td>
<td>3.50</td>
<td>3.84</td>
<td>10.50</td>
<td>92</td>
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<tr>
<td>REC</td>
<td>43X22</td>
<td>000</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td></td>
<td>0.065</td>
<td>0.039</td>
<td>2.80</td>
<td>71</td>
<td>18</td>
<td>3</td>
<td>5</td>
<td>30</td>
<td>15</td>
</tr>
</tbody>
</table>
FACILITY DIRECT PE INPUTS  CPT CODE(S): 43235, 43X21, 43X22
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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>000</td>
</tr>
<tr>
<td>43X21</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon</td>
<td>000</td>
</tr>
<tr>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>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.</td>
</tr>
<tr>
<td>43X21</td>
<td>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.</td>
</tr>
<tr>
<td>43X22</td>
<td>A 45-year-old female who is six months post placement of an intragastric balloon presents for removal of the balloon.</td>
</tr>
</tbody>
</table>

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, 43X21 and 43X22. 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 43X21 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 43X22 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?

<table>
<thead>
<tr>
<th>Facility Direct PE Inputs</th>
<th>CPT Code(s): 43235, 43X21, 43X22</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPECIALTY SOCIETY(IES):</td>
<td>ACG, AGA, ASGE, SAGES</td>
</tr>
<tr>
<td>PRESENTER(S):</td>
<td>R. Bruce Cameron, MD (ACG),</td>
</tr>
<tr>
<td></td>
<td>Shivan Mehta, MD (AGA),</td>
</tr>
<tr>
<td></td>
<td>Patricia Garcia, MD (AGA),</td>
</tr>
<tr>
<td></td>
<td>Seth Gross, MD (ASGE),</td>
</tr>
<tr>
<td></td>
<td>Vivek Kaul, MD (ASGE),</td>
</tr>
<tr>
<td></td>
<td>Sheth Ketan, MD (SAGES),</td>
</tr>
<tr>
<td></td>
<td>Dmitry Nepomnayshy, MD (SAGES)</td>
</tr>
</tbody>
</table>

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 43X21 and 43X22 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.

<table>
<thead>
<tr>
<th>Activity Code</th>
<th>Description of Clinical Activities</th>
<th>Use of Clinical Staff for Endoscopy</th>
<th>EGD base code</th>
<th>Balloon placement</th>
<th>Balloon removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA001</td>
<td>Complete pre-service diagnostic and referral forms</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CA002</td>
<td>Coordinate pre-surgery services (including test results)</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>CA003</td>
<td>Schedule space and equipment in facility</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CA004</td>
<td>Provide pre-service education/obtain consent</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>CA005</td>
<td>Complete pre-procedure phone calls and prescription</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other Clinical Activity</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>

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, 43X21 and 43X22 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, 43X21 and 43X22 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 Latitide 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 |
| 43X21 and 43X22 = 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).
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, 43X21, 43X22

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>000</td>
</tr>
<tr>
<td>43X21</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon</td>
<td>000</td>
</tr>
<tr>
<td>43X22</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)</td>
<td>000</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>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.</td>
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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, 43X21 and 43X22. 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 43X21 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
Nonfacility Direct PE Inputs

CPT Code(s): 43235, 43X21, 43X22

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), Sheeth Ketan, MD (SAGES), Dmitry Nepomnayshy, MD (SAGES)

AMA/Specialty Society Relative Value Update Committee (RUC) Practice Expense Summary of Recommendation (SOR)

2

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 43X22 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 nonfacility. According to the RUC database, 43235 was billed 7.0% of the time with non-facility office E/M.
NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 43235, 43X21, 43X22

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)

Codes 43X21 and 43X22 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 43X21 and 43X22 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.

<table>
<thead>
<tr>
<th>Activity Code</th>
<th>Description of Pre-service Clinical Activities - 000 and 010</th>
<th>Use of clinical staff</th>
<th>Extensive use of clinical staff</th>
<th>EGD base code</th>
<th>Balloon insertion</th>
<th>Balloon removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA001</td>
<td>Complete pre-service diagnostic and referral forms</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>CA002</td>
<td>Coordinate pre-surgery services (including test results)</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CA003</td>
<td>Schedule space and equipment in facility</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CA004</td>
<td>Provide pre-service education/obtain consent</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CA005</td>
<td>Complete pre-procedure phone calls and prescription</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Other clinical activity</td>
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<td>18</td>
<td>9</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

**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)*

***

**43X21 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.

**43X21 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, antispasmodic, 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](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**

**43X21 Post-Service Clinical Labor Activities = RN/LPN/MTA**
We are not recommending any additional minutes beyond the standard for CA037 (Conduct patient communications).

***

**43X22 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.

**43X22 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**

**43X22 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**
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, 43X21 and 43X22, 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 43X22 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)

   **43X21 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)

   **43X21 Intra-Service Clinical Labor Activities = RN/LPN/MTA**
   - 3 minutes to greet patient, provide gowning, ensure appropriate medical records are available (CA009)
NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 43235, 43X21, 43X22

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)

- 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)

43X22 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)

43235, 43X21 and 43X22 Post-Service Clinical Labor Activities = RN/LPN/MTA

- 3 minutes to conduct patient communications (CA037)

c. Post-service period:

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.

43X21 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.
43X22 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](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_43X21_43X22.” These invoices contain prices for the ORBERA Intragastic 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
NONFACILITY DIRECT PE INPUTS  
CPT CODE(S): 43235, 43X21, 43X22  
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)

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)  
gluteraldehyde 3.4% (Cidex, Maxicide, Wavicide) (SM018) oz, 32 ($2.6212)  
gluteraldehyde 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 Latitude 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
NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 43235, 43X21, 43X22

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)

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, 43X21 and 43X22 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
1 RUC Practice Expense Spreadsheet
2
3
RUC Collaboration Website

4

Meeting Date: April 2021
Clinical
Revision Date (if applicable): 4/12/2021
Activity Code Tab: 8 (Endoscopic Bariatric Device Procedures)
Specialty: ACG, AGA, ASGE, SAGES

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CA039
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100 Supply Code
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102 SA042
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109

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SA043
SA048
SB001
SB006
SB027
SB034
SB039

LOCATION
GLOBAL PERIOD
TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND
EQUIPMENT TIME
TOTAL CLINICAL STAFF TIME
TOTAL PRE-SERVICE CLINICAL STAFF TIME
TOTAL SERVICE PERIOD CLINICAL STAFF TIME
TOTAL POST-SERVICE CLINICAL STAFF TIME
TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE
PRE-SERVICE PERIOD
Start: Following visit when decision for surgery/procedure made

Other activity: please include short clinical description here and type new
End: When patient enters office/facility for surgery/procedure
SERVICE PERIOD
Start: When patient enters office/facility for surgery/procedure:
Pre-Service (of service period)

Other activity: please include short clinical description here and type new
Intra-service (of service period)

Other activity: please include short clinical description here and type new
Post-Service (of service period)

Other activity: please include short clinical description here and type new
End: Patient leaves office/facility
POST-SERVICE PERIOD
Start: Patient leaves office/facility
Office visits: List Number and Level of Office Visits
99211 16 minutes
99212 27 minutes
99213 36 minutes
99214 53 minutes
99215 63 minutes
Other activity: please include short clinical description here and type new
End: with last office visit before end of global period
MEDICAL SUPPLIES
TOTAL COST OF SUPPLY QUANTITY x PRICE

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Clinical Staff
Type Code

E

Clinical
Staff Type

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L037D
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L037D

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Clinical Staff
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43235

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Esophagoscopy, flexible,
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### RUC Practice Expense Spreadsheet

#### Meeting Date: April 2021

#### Revision Date (if applicable): 4/12/2021

#### Specialty: ACG, AGA, ASGE, SAGES

### Tab: 8 (Endoscopic Bariatric Device Procedures)

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 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 (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 49X12 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 cranio-caudal distance of 8 cm (49X04).” As stated by the specialties, hernias of this sort are all generally the same piece of bowel CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 49X01 and 49X04 with April 2021 RUC recommended work RVUs, the total work RVU value would be greater (total work RVUs recommended = 20.27 for 49X01 and 49X04) than for just reporting the service as 49X04 (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 49X02 (total work RVUs recommended = 15.27 for 49X01 and 49X02).

Table 1: Anterior Abdominal Hernia Repair: Work RVU Recommendations

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>DESC</th>
<th>Recommended Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>14.24</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>14.00</td>
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<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>14.88</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>16.50</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>16.97</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>18.00</td>
</tr>
</tbody>
</table>

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Initial Abdominal Hernia Repair

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

The RUC reviewed the survey results from 39 surgeons for CPT code 49X01 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 49X01. 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 49X01 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 49X01 to MPC code 52352 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 49X01 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 49X01.

49X02 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 49X02 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 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 day 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 49X02 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 49X02. The RUC recommends a work RVU of 9.00 for CPT code 49X02.

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49X03 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 49X03 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 49X03 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 49X03’s higher total time and is appropriately lower than that of top key reference service 11006 given 49X03’s lower intra-service and total time. **The RUC recommends a work RVU of 10.80 for CPT code 49X03.**

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49X04 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 49X04 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 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 49X04 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 49X04 with appropriate work RVUs and noted that the recommended work RVU of 14.00 is appropriately higher than that of MPC code 37244 given 49X04’s higher intra-service and total time and is appropriately lower than that of top key reference service 11005 given 49X04’s lower total time. The RUC recommends a work RVU of 14.00 for CPT code 49X04.
49X05 *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 49X05 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 49X05 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 49X05 is much more complex than second key reference service 11005 and 60 percent of survey respondents determined that 49X05 is somewhat more complex than 11005, which supports a slightly higher work RVU value for 49X05. The higher recommended intra-service and total time for 49X05 supports a higher work RVU value than 37244. The RUC recommends a work RVU of 14.88 for CPT code 49X05.
49X06 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 49X06 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; 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 49X06 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 49X06 is much more complex than second key reference service 61624 and 44 percent of survey respondents determined that 49X06 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 49X06.**

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Recurrent Abdominal Hernia Repair

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

The RUC reviewed the survey results from 41 surgeons for CPT code 49X07 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 49X01 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 49X07. 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 49X07 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 49X07 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 49X07.
49X08 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 49X08 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 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 49X08 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 48X08 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 49X08.**

49X09 *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 49X09 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 49X09 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 of which require more physician work and time than 49X09; thus it is appropriately valued slightly lower. The RUC recommends a work RVU of 12.00 for CPT code 49X09.

49X10 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 49X10 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 an 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).
To support a work RVU of 16.50, the RUC compared CPT code 49X10 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 thorascoscopic 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 49X10.

49X11  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 49X11 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 49X10 involves an incarcerated/strangulated hernia, the hernia repair associated with CPT code 49X11 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 49X11.

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; CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 49X11 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 49X11.

49X12 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 49X12 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 49X12 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 49X12 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 49X12.

Parastomal Hernia Repair

49X13 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 49X13 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 49X13 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 49X13 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 49X13. The RUC recommends a work RVU of 14.24 for CPT code 49X13.

**49X14 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 49X14 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 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 49X14 than that associated with repair of a reducible parastomal hernia for 49X13.

To support a work RVU of 18.00, the RUC compared CPT code 49X14 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, CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 49X14 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 49X14 requires less physician work and time, thus is valued appropriately slightly lower than 33891. The RUC noted that 49X14 is valued appropriately higher than 49X13 given the piece of incarcerated/strangulated bowel associated with 49X14. **The RUC recommends a work RVU of 18.00 for CPT code 49X14.**

**Removal of Mesh or Other Prosthesis**

*49X15 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 49X15 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 49X15 to specify “total or near total non-infected” mesh removal.**

The RUC reviewed the survey results from 150 surgeons for CPT code 49X15 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 49X15 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 CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
noted that the survey respondents indicated the intensity and complexity of CPT code 49X15 was greater than both CPT code 11008 and CPT code 35572. Both of the reference codes are performed via an open approach with direct visualization, while 49X15 will typically be performed via a laparoscopic or robotic approach internally. The RUC also compared CPT code 49X15 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 49X15. The RUC recommends a work RVU of 5.00 for CPT code 49X15.

**Implantation of Absorbable Mesh or Other Prosthesis for Delayed Closure**

157X1 *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 157X1 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 157X1 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 157X1 was appropriately bracketed by these two codes using magnitude estimation. The RUC recommends a work RVU of 8.00 for CPT code 157X1.
RUC Referral to CPT
The RUC recommends CPT code 49X15 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 49X15 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.

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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

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<tr>
<td>157X1</td>
<td>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</td>
</tr>
<tr>
<td>+11008</td>
<td>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)</td>
</tr>
<tr>
<td>+15777</td>
<td>Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
(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 49X01-49X14)

(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 49491-4952549587)

(For anterior abdominal hernia(s) repair, see 49X01-49X12)

(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)
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(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 49X01-49X14)

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)

(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)

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)

(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)

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>49521</td>
<td>incarcerated or strangulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49525</td>
<td>Repair inguinal hernia, sliding, any age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(For incarcerated or strangulated inguinal hernia repair, see 49496, 49501, 49507, 49521)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49540</td>
<td>Repair lumbar hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49550</td>
<td>Repair initial femoral hernia, any age; reducible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49553</td>
<td>incarcerated or strangulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49555</td>
<td>Repair recurrent femoral hernia; reducible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(For incarcerated or strangulated inguinal hernia repair, see 49496, 49501, 49507, 49521)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(D)49560</td>
<td>Repair initial incisional or ventral hernia; reducible</td>
<td>090</td>
<td>N/A</td>
</tr>
<tr>
<td>(D)49561</td>
<td>incarcerated or strangulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(49560, 49561 have been deleted. For repair of initial incisional or ventral hernia, see 49X01-49X06)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(D)49565</td>
<td>Repair recurrent incisional or ventral hernia; reducible</td>
<td>090</td>
<td>N/A</td>
</tr>
<tr>
<td>(D)49566</td>
<td>incarcerated or strangulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(49565, 49566 have been deleted. For repair of recurrent incisional or ventral hernia, see 49X07-49X12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Work RVU</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49568</td>
<td>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 49X01-49X12)</td>
<td>4.88</td>
<td>N/A</td>
<td>(2021 work RVU = 4.88)</td>
</tr>
<tr>
<td>(D)49570</td>
<td>Repair epigastric hernia (eg., preperitoneal fat), reducible (separate procedure)</td>
<td>6.05</td>
<td>N/A</td>
<td>(2021 work RVU = 6.05)</td>
</tr>
<tr>
<td>(D)49572</td>
<td>incarcerated or strangulated (49570, 49572 have been deleted. For epigastric hernia repair see 49X01-49X12)</td>
<td>7.87</td>
<td>N/A</td>
<td>(2021 work RVU = 7.87)</td>
</tr>
<tr>
<td>(D)49580</td>
<td>Repair umbilical hernia, younger than age 5 years; reducible</td>
<td>4.47</td>
<td>N/A</td>
<td>(2021 work RVU = 4.47)</td>
</tr>
<tr>
<td>(D)49582</td>
<td>incarcerated or strangulated (49580, 49582 have been deleted. For umbilical hernia repair younger than age 5 years, see 49X01-49X12)</td>
<td>7.13</td>
<td>N/A</td>
<td>(2021 work RVU = 7.13)</td>
</tr>
<tr>
<td>(D)49585</td>
<td>Repair umbilical hernia, age 5 years or older; reducible</td>
<td>6.59</td>
<td>N/A</td>
<td>(2021 work RVU = 6.59)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>2021 Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>49587</td>
<td>incarceration or strangulated</td>
<td>090</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(49585, 49587 have been deleted. For umbilical hernia repair age 5 years and older, see 49X01-49X12)</td>
<td></td>
<td>(2021 work RVU = 7.08)</td>
</tr>
<tr>
<td>49590</td>
<td>Repair spigelian hernia</td>
<td>090</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(49590 has been deleted. For spigelian hernia repair, see 49X01-49X12)</td>
<td></td>
<td>(2021 work RVU = 8.90)</td>
</tr>
</tbody>
</table>

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 craniocaudal 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 49X15 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Total Length</th>
<th>CPT Code</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>C2</td>
<td>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</td>
<td>000</td>
<td>6.27</td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td>C3</td>
<td>less than 3 cm, incarcerated or strangulated</td>
<td>000</td>
<td>9.00</td>
<td></td>
</tr>
<tr>
<td>49X03</td>
<td>C4</td>
<td>3 cm to 10 cm, reducible</td>
<td>000</td>
<td>10.80</td>
<td></td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
| 49X04 | C5 | 3 cm to 10 cm, incarcerated or strangulated | 000 | 14.00 |
| 49X05 | C6 | greater than 10 cm, reducible | 000 | 14.88 |
| 49X06 | C7 | greater than 10 cm, incarcerated or strangulated | 000 | 20.00 |
| 49X07 | 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 |
| 49X08 | C9 | less than 3 cm, incarcerated or strangulated | 000 | 10.79 |
| 49X09 | C10 | 3 cm to 10 cm, reducible | 000 | 12.00 |
| 49X10 | C11 | 3 cm to 10 cm, incarcerated or strangulated | 000 | 16.50 |
| 49X11 | C12 | greater than 10 cm, reducible | 000 | 16.97 |
| 49X12 | C13 | greater than 10 cm, incarcerated or strangulated | 000 | 24.00 |
| 49X13 | 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 |
| 49X14 | C15 | incarcerated or strangulated | 000 | 18.00 |
| 49X15 | 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 49X15 in conjunction with 49X01-49X14) (For removal of infected mesh, use 11008) | ZZZ | 5.00 |
**Laparoscopy**

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

49650 Laparoscopy, surgical; repair initial inguinal hernia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49651</td>
<td>repair recurrent inguinal hernia</td>
<td>000</td>
<td>N/A</td>
</tr>
</tbody>
</table>

49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49652</td>
<td>-</td>
<td>000</td>
<td>(2021 work RVU = 11.92)</td>
</tr>
</tbody>
</table>

49653 Laparoscopy, surgical, repair, incarcerated or strangulated ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49653</td>
<td>-</td>
<td>000</td>
<td>(2021 work RVU = 14.94)</td>
</tr>
</tbody>
</table>

49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49654</td>
<td>-</td>
<td>000</td>
<td>(2021 work RVU = 13.76)</td>
</tr>
</tbody>
</table>

49655 Laparoscopy, surgical, repair, incarcerated or strangulated incisional hernia (includes mesh insertion, when performed); reducible

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49655</td>
<td>-</td>
<td>000</td>
<td>(2021 work RVU = 16.84)</td>
</tr>
</tbody>
</table>

49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(D)49656</td>
<td>-</td>
<td>000</td>
<td>(2021 work RVU = 15.08)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>RVU</td>
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</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>49657</td>
<td>incarcerated or strangulated</td>
<td>090</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Do not report 49657 in conjunction with 44180, 49568)
(49656, 49657 have been deleted. To report laparoscopic repair of recurrent incisional hernia, see 49X07-49X12)

090 (2021 work RVU = 22.11)

## Category III Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0437T</td>
<td>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)</td>
</tr>
</tbody>
</table>

(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 49X01-49X14)

(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 157X1)
CPT Code: 49X01

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X01 Tracking Number C2
Global Period: 000 Current Work RVU:

Original Specialty Recommended RVU: **6.27**
Presented Recommended RVU: **6.27**
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(les):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X01</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>39</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
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<tbody>
<tr>
<td>Service Performance Rate</td>
<td>3.00</td>
<td>10.00</td>
<td>20.00</td>
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<td>16.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
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</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>20.00</td>
<td>40.00</td>
<td>45.00</td>
<td>60.00</td>
<td>90.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 20.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x</td>
<td>12x</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>55x</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th></th>
<th>Speciality Recommended Pre-Service Time</th>
<th>Speciality Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>25.00</td>
<td>33.00</td>
<td>-8.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>3.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>15.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>45.00</td>
<td>45.00</td>
<td>45.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Speciality Recommended Post-Service Time</th>
<th>Speciality Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>20.00</td>
<td>33.00</td>
<td>-13.00</td>
</tr>
</tbody>
</table>
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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31600</td>
<td>000</td>
<td>5.56</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Tracheostomy, planned (separate procedure);

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>43210</td>
<td>000</td>
<td>7.75</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36475</td>
<td>000</td>
<td>5.30</td>
<td>RUC Time</td>
<td>109,583</td>
</tr>
</tbody>
</table>

CPT Descriptor: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>52352</td>
<td>000</td>
<td>6.75</td>
<td>RUC Time</td>
<td>24,811</td>
</tr>
</tbody>
</table>

CPT Descriptor: Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)

**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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X01</th>
<th>Top Key Reference CPT Code: 31600</th>
<th>2nd Key Reference CPT Code: 43210</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>43.00</td>
<td>60.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>30.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>20.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>108.00</td>
<td>120.00</td>
<td>148.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Effort and Judgment</td>
<td>33%</td>
<td>67%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>33%</td>
<td>50%</td>
<td>17%</td>
</tr>
</tbody>
</table>
### Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>17%</td>
<td>83%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>50%</td>
<td>17%</td>
</tr>
</tbody>
</table>

- 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

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>33%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
</tbody>
</table>

- The number of possible diagnoses 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

- Technical skill required
- Physical effort required

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

- 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

---

### 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 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 laparoscopic/robotic under pneumoperitoneum.

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 157X1, 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 inpatient 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 – 49X01**
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 49X01 is somewhat less or similar than reference code 31600. Ref2: The respondents indicated the intensity/complexity of survey code 49X01 is similar to somewhat more than reference code 43210.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPPUT</th>
<th>IUPT</th>
<th>IUPT</th>
<th>IUPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>36475</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated</td>
<td>5.30</td>
<td>0.097</td>
<td>0.056</td>
<td>94</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>52352</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)</td>
<td>6.75</td>
<td>0.118</td>
<td>0.057</td>
<td>118</td>
<td>53</td>
<td>45</td>
</tr>
</tbody>
</table>

**Other Code Comparison**
Codes 45390 and 31276, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPPUT</th>
<th>IUPT</th>
<th>IUPT</th>
<th>IUPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>45390</td>
<td>Colonoscopy, flexible; with endoscopic mucosal resection</td>
<td>6.04</td>
<td>0.117</td>
<td>0.073</td>
<td>83</td>
<td>23</td>
<td>45</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed</td>
<td>6.75</td>
<td>0.127</td>
<td>0.069</td>
<td>98</td>
<td>33</td>
<td>45</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>25th</td>
<td>12.00</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>15.50</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>median</td>
<td>16.65</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>median</td>
<td>17.00</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>median</td>
<td>18.50</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>median</td>
<td>18.53</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>75th</td>
<td>20.25</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>75th</td>
<td>24.24</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>75th</td>
<td>25.00</td>
</tr>
</tbody>
</table>

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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm</th>
<th>Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>-24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>0.089</td>
<td></td>
<td>0.053</td>
<td></td>
<td></td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>0.079</td>
<td></td>
<td>0.058</td>
<td></td>
<td></td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>0.075</td>
<td></td>
<td>0.057</td>
<td></td>
<td></td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>0.085</td>
<td></td>
<td>0.059</td>
<td></td>
<td></td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>0.088</td>
<td></td>
<td>0.062</td>
<td></td>
<td></td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>0.076</td>
<td></td>
<td>0.058</td>
<td></td>
<td></td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>0.078</td>
<td></td>
<td>0.060</td>
<td></td>
<td></td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>0.089</td>
<td></td>
<td>0.066</td>
<td></td>
<td></td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>0.097</td>
<td></td>
<td>0.068</td>
<td></td>
<td></td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>0.098</td>
<td></td>
<td>0.068</td>
<td></td>
<td></td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td>1 overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>0.093</td>
<td></td>
<td>0.067</td>
<td></td>
<td></td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>0.086</td>
<td></td>
<td>0.064</td>
<td></td>
<td></td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106</td>
<td>0.069</td>
<td>0.098</td>
<td></td>
<td>0.069</td>
<td></td>
<td></td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>0.099</td>
<td></td>
<td>0.071</td>
<td></td>
<td></td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115</td>
<td>0.073</td>
<td>0.080</td>
<td></td>
<td>0.073</td>
<td></td>
<td></td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>0.113</td>
<td></td>
<td>0.078</td>
<td></td>
<td></td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td>1 inpatient</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>0.104</td>
<td></td>
<td>0.075</td>
<td></td>
<td></td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td>1 inpatient</td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Commonly</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>39265</td>
<td>89 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>2181</td>
<td>4.99 %</td>
</tr>
<tr>
<td>Other Surgery</td>
<td>2181</td>
<td>4 %</td>
</tr>
</tbody>
</table>

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:
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 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.

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
CPT Code: 49X02

CSM/AMA SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X02
Tracking Number C3
Original Specialty Recommended RVU: 9.00
Presented Recommended RVU: 9.00
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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X02</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>39</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
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<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>5.00</td>
<td>10.00</td>
<td>20.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>5.60</td>
<td>9.00</td>
<td>12.00</td>
<td>15.48</td>
<td>20.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td>35.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td></td>
<td></td>
<td>30.00</td>
<td>50.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>20.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s)</td>
<td>20.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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); 99355 (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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>49X02</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong></td>
<td>9.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>35.00</td>
<td>40.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>3.00</td>
<td>3.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td>33.00</td>
<td>-3.00</td>
</tr>
</tbody>
</table>
CPT Code: 49X02

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99240x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>33956</td>
<td>000</td>
<td>16.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36905</td>
<td>000</td>
<td>9.00</td>
<td>RUC Time</td>
<td>41,205</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>000</td>
<td>10.42</td>
<td>RUC Time</td>
<td>14,028</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X02

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X02</th>
<th>Top Key Reference CPT Code: 11005</th>
<th>2nd Key Reference CPT Code: 33956</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>53.00</td>
<td>60.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>120.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>55.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>143.00</td>
<td>265.00</td>
<td>250.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>17%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>17%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>17%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
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<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>17%</td>
<td>67%</td>
<td>17%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
</tbody>
</table>

## 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 classify procedures performed in the facility (ie, not CPT physician procedures). 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 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 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 157X1, 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.
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 follow up 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 inpatient 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 – 49X02**

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 49X02 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49X02 is similar to reference code 33956.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>36905</td>
<td>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</td>
<td>9.00</td>
<td>0.106</td>
<td>0.071</td>
<td>126</td>
<td>31</td>
<td>75</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td><strong>Initial, I/S, &lt; 3cm</strong></td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>143</td>
<td>53</td>
<td>60</td>
<td>30</td>
<td>99231</td>
</tr>
<tr>
<td>36906</td>
<td>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</td>
<td>10.42</td>
<td>0.104</td>
<td>0.074</td>
<td>141</td>
<td>31</td>
<td>90</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
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 Code Comparison

Codes 33991 and 92920, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>INP</th>
<th>WPUT</th>
<th>TOTAL</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>33991</td>
<td>Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture</td>
<td>8.84</td>
<td>0.129</td>
<td>0.078</td>
<td>113</td>
<td>25</td>
<td>60</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>143</td>
<td>53</td>
<td>60</td>
<td>30</td>
<td>99231</td>
<td></td>
</tr>
<tr>
<td>92920</td>
<td>Percutaneous transluminal coronary angioplasty; single major coronary artery or branch</td>
<td>9.85</td>
<td>0.126</td>
<td>0.078</td>
<td>127</td>
<td>29</td>
<td>68</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
</tbody>
</table>
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 of the recommendations for 49X01-49X14 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 ranked.

To summarize, the AMA table, which is included in the Research Subcommittee agenda for this meeting, showed that the IWPUT was calculated 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).

**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.

### Services Reported with Multiple CPT Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>DEC</th>
<th>REC RVW</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td></td>
<td>1.60</td>
<td>0.084 0.053</td>
<td>0.089 0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113 0.058</td>
<td>0.079 0.058</td>
<td>108 43</td>
<td>45 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105 0.057</td>
<td>0.075 0.057</td>
<td>135 55</td>
<td>60 20</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123 0.063</td>
<td>0.085 0.059</td>
<td>153 53</td>
<td>60 20</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120 0.065</td>
<td>0.088 0.062</td>
<td>175 60</td>
<td>75 20</td>
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<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101 0.062</td>
<td>0.076 0.058</td>
<td>185 55</td>
<td>90 20</td>
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<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102 0.063</td>
<td>0.078 0.060</td>
<td>200 60</td>
<td>100 20</td>
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<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107 0.066</td>
<td>0.089 0.066</td>
<td>237 70</td>
<td>120 25</td>
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<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121 0.074</td>
<td>0.097 0.068</td>
<td>245 65</td>
<td>120 20</td>
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<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123 0.074</td>
<td>0.098 0.068</td>
<td>250 70</td>
<td>120 20</td>
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</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109 0.067</td>
<td>0.093 0.067</td>
<td>275 70</td>
<td>140 25</td>
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<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101 0.064</td>
<td>0.086 0.064</td>
<td>288 70</td>
<td>150 28</td>
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</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106 0.069</td>
<td>0.098 0.069</td>
<td>40 6</td>
<td>22 12</td>
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</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113 0.071</td>
<td>0.099 0.071</td>
<td>285 70</td>
<td>150 25</td>
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<td></td>
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<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115 0.073</td>
<td>0.080 0.073</td>
<td>55 9</td>
<td>30 16</td>
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<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127 0.078</td>
<td>0.113 0.078</td>
<td>310 70</td>
<td>160 25</td>
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</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117 0.075</td>
<td>0.104 0.075</td>
<td>335 70</td>
<td>180 30</td>
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</tbody>
</table>

*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).
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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>49561</td>
<td>Repair initial incisional or ventral hernia; incarcerated or strangulated</td>
<td>090</td>
</tr>
<tr>
<td>49572</td>
<td>Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated</td>
<td>090</td>
</tr>
<tr>
<td>49587</td>
<td>Repair umbilical hernia, age 5 years or older; incarcerated or strangulated</td>
<td>090</td>
</tr>
<tr>
<td>49590</td>
<td>Repair spigelian hernia</td>
<td>090</td>
</tr>
<tr>
<td>49653</td>
<td>Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
</tr>
<tr>
<td>49655</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
</tr>
<tr>
<td>49568</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>Commonly</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
</table>

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 and percentage for each specialty. Please explain the rationale for this estimate. Specialty estimate - See supplemental file with details
CPT Code: 49X02

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

---

**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
CPT Code: 49X03

Summary of Recommendation

CPT Code: 49X03 Tracking Number C4
Global Period: 000

Original Specialty Recommended RVU: 10.80
Presented Recommended RVU: 10.80
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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(les):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X03</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>41</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.00</td>
<td>8.00</td>
<td>20.00</td>
<td>30.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey RVW:</th>
<th>8.00</th>
<th>10.80</th>
<th>13.00</th>
<th>15.00</th>
<th>18.32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>40.00</td>
<td>60.00</td>
<td>90.00</td>
<td>120.00</td>
<td>240.00</td>
</tr>
</tbody>
</table>

| Immediate Post Service-Time: | 20.00 |

**Post Operative 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 |

**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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>49X03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong></td>
<td>10.80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Specialty Recommended Pre-Service Time</strong></th>
<th><strong>Adjustments/Recommended Pre-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>30.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>90.00</td>
</tr>
</tbody>
</table>

**9B General Anes or Complex Regional Blk/Cmplx Proc**

<table>
<thead>
<tr>
<th><strong>Specialty Recommended Post-Service Time</strong></th>
<th><strong>Adjustments/Recommended Post-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
</tr>
</tbody>
</table>

**Specialty Society Recommended Post Time Package**

**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)**

1. Pre-Service Evaluation Time: 30.00
2. Pre-Service Positioning Time: 10.00
3. Pre-Service Scrub, Dress, Wait Time: 15.00
4. Intra-Service Time: 90.00
5. 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

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11006</td>
<td>000</td>
<td>13.10</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**Key CPT Code** 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11004</td>
<td>000</td>
<td>10.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**Key CPT Code** 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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>000</td>
<td>10.42</td>
<td>RUC Time</td>
<td>14,028</td>
</tr>
</tbody>
</table>

**MPC CPT Code 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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

**MPC CPT Code 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
CPT Code: 49X03
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.**

<table>
<thead>
<tr>
<th>Number of respondents who choose Top Key Reference Code: 8</th>
<th>% of respondents: 19.5 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents who choose 2nd Key Reference Code: 5</td>
<td>% of respondents: 12.1 %</td>
</tr>
</tbody>
</table>

**TIME ESTIMATES (Median)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X03</th>
<th>Top Key Reference CPT Code: 11006</th>
<th>2nd Key Reference CPT Code: 11004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>55.00</td>
<td>65.00</td>
<td>65.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>90.00</td>
<td>120.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>55.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>175.00</td>
<td>270.00</td>
<td>240.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>13%</td>
<td>0%</td>
<td>75%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13%</td>
<td>25%</td>
<td>63%</td>
</tr>
</tbody>
</table>
**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>13%</td>
<td>0%</td>
<td>88%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>13%</td>
<td>25%</td>
<td>63%</td>
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</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>25%</td>
<td>13%</td>
<td>63%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>60%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
<td>Technical skill required</td>
<td>20%</td>
<td>0%</td>
<td>80%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
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</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>60%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 157X1, 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.
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
CPT Code: 49X03

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 follow up 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 inpatient 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 – 49X03**

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 anesthesiology 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 49X03 is somewhat more than reference code 11006. Ref 2: The respondents indicated the intensity/complexity of survey code 49X03 is similar to somewhat more than reference code 11004.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>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</td>
<td>10.42</td>
<td>0.104</td>
<td>0.074</td>
<td>141</td>
<td>31</td>
<td>90</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X03

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm, 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</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>175</td>
<td>55</td>
<td>90</td>
<td>30</td>
<td>99231</td>
</tr>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 92920 and 92924, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>92920</td>
<td>Percutaneous transluminal coronary angioplasty; single major coronary artery or branch</td>
<td>9.85</td>
<td>0.126</td>
<td>0.078</td>
<td>127</td>
<td>29</td>
<td>68</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>175</td>
<td>55</td>
<td>90</td>
<td>30</td>
<td>99231</td>
</tr>
<tr>
<td>92924</td>
<td>Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch</td>
<td>11.74</td>
<td>0.125</td>
<td>0.082</td>
<td>143</td>
<td>29</td>
<td>84</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>108</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>143</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>165</td>
</tr>
</tbody>
</table>
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 post 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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Time Total</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33 -26</th>
<th>-32 -25</th>
<th>-31 -24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>250</td>
<td>70</td>
<td>120</td>
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<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
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</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106</td>
<td>0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115</td>
<td>0.073</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
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</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
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<td>inpatient</td>
</tr>
</tbody>
</table>

* 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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Global Period</th>
<th>Work RVUs</th>
<th>Pre, Intra, Post Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49560</td>
<td>Repair initial incisional or ventral hernia; reducible</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49570</td>
<td>Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49585</td>
<td>Repair umbilical hernia, age 5 years or older; reducible</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49590</td>
<td>Repair spigelian hernia</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49652</td>
<td>Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49654</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible</td>
<td>090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49658</td>
<td>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)</td>
<td>ZZZ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty general surgery</td>
<td>Commonly</td>
</tr>
<tr>
<td>Specialty colorectal surgery</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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
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 and percentage for each specialty. Please explain the rationale for this estimate.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>11396</td>
<td>90.00 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>633</td>
<td>4.99 %</td>
</tr>
<tr>
<td>Other Surgery</td>
<td>633</td>
<td>4.99 %</td>
</tr>
</tbody>
</table>

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
CPT Code: 49X04

Summary of Recommendation

CPT Code: 49X04  Tracking Number: C5

Original Specialty Recommended RVU: 16.65
Presented Recommended RVU: 16.65
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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X04</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>41</td>
</tr>
</tbody>
</table>

#### Description of Sample:
Random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>3.00</td>
<td>8.00</td>
<td>20.00</td>
<td>100.00</td>
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</table>

<table>
<thead>
<tr>
<th>Survey RVW:</th>
<th>10.90</th>
<th>14.00</th>
<th>16.65</th>
<th>20.00</th>
<th>24.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>35.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
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<td>90.00</td>
<td>120.00</td>
<td>150.00</td>
<td>300.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td><strong>20.00</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Post Operative Visits

| Critical Care time/visit(s): | 99291x | 99292x |
| Other Hospital time/visit(s): | 99231x | 99232x | 1.00 | 99233x | 0.00 |
| Discharge Day Mgmt:           | 99238x | 99239x | 0.00 | 99217x | 0.00 |
| Office time/visit(s):        | 99211x | 12x | 99212x | 13x | 99213x | 14x | 99214x | 0.00 | 15x | 0.00 |
| Prolonged Services:          | 99354x | 55x | 0.00 | 56x | 0.00 | 57x | 0.00 |
| Sub Obs Care:                | 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); 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)

**Specialty**

- 4-FAC Difficult Patient/Difficult Procedure

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>Recommended Physician Work RVU: 14.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X04</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Service Evaluation Time:</th>
<th>35.00</th>
<th>40.00</th>
<th>-5.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>3.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>120.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

**Specialty**

- 9B General Anes or Complex Regional Blk/Cmplx Proc

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>40.00</th>
<th>33.00</th>
<th>7.00</th>
</tr>
</thead>
</table>
CPT Code: 49X04

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>33891</td>
<td>000</td>
<td>20.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>000</td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

Other Reference CPT Code

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X04</th>
<th>Top Key Reference CPT Code: 11005</th>
<th>2nd Key Reference CPT Code: 33891</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>65.00</td>
<td>60.00</td>
<td>110.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>120.00</td>
<td>120.00</td>
<td>173.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>40.00</td>
<td>30.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>55.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>225.00</td>
<td>265.00</td>
<td>323.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>18%</td>
<td>9%</td>
<td>45%</td>
<td>27%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>18%</td>
<td>18%</td>
<td>64%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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 (i.e., 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 (e.g., 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 (e.g., 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 157X1, 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
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 follow up 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 inpatient 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 – 49X04**

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 49X04 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49X04 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 Code: 49X04

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPWT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>225</td>
<td>65</td>
<td>120</td>
<td>40</td>
<td>99232</td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 61645 and 93591, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPWT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>61645</td>
<td>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)</td>
<td>15.00</td>
<td>0.121</td>
<td>0.062</td>
<td>241</td>
<td>58</td>
<td>100</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>225</td>
<td>65</td>
<td>120</td>
<td>40</td>
<td>99232</td>
</tr>
<tr>
<td>93591</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve</td>
<td>17.97</td>
<td>0.135</td>
<td>0.086</td>
<td>208</td>
<td>58</td>
<td>120</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>108</td>
</tr>
</tbody>
</table>

\[ R^2 = 0.982 \]
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, it has become difficult to compare IWPUT (and WPUT) for codes with different global periods because of the level of true for codes that have a significant amount of pre-service and post-service work.

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.

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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33 -26</th>
<th>-32 -25</th>
<th>-31 -24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084 IWPUT</td>
<td>0.089 IWPUT</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113 IWPUT</td>
<td>0.079 IWPUT</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105 IWPUT</td>
<td>0.075 IWPUT</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123 IWPUT</td>
<td>0.085 IWPUT</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120 IWPUT</td>
<td>0.088 IWPUT</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101 IWPUT</td>
<td>0.076 IWPUT</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102 IWPUT</td>
<td>0.078 IWPUT</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107 IWPUT</td>
<td>0.089 IWPUT</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121 IWPUT</td>
<td>0.097 IWPUT</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123 IWPUT</td>
<td>0.098 IWPUT</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109 IWPUT</td>
<td>0.093 IWPUT</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101 IWPUT</td>
<td>0.086 IWPUT</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106 IWPUT</td>
<td>0.098 IWPUT</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113 IWPUT</td>
<td>0.099 IWPUT</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115 IWPUT</td>
<td>0.080 IWPUT</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127 IWPUT</td>
<td>0.113 IWPUT</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117 IWPUT</td>
<td>0.104 IWPUT</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
</tbody>
</table>

* 2021 Formula: IWPUT calculation based on evaluation, positioning, immediate post op 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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global Period</th>
<th>Work RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>49561</td>
<td>Repair initial incisional or ventral hernia; incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49572</td>
<td>Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49587</td>
<td>Repair umbilical hernia, age 5 years or older; incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49590</td>
<td>Repair spigelian hernia</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49653</td>
<td>Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49655</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49658</td>
<td>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)</td>
<td>ZZZ</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty general surgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Specialty colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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
 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

**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
CPT Code: 49X05  
Tracking Number: C6  
Original Specialty Recommended RVU: 17.00

Presented Recommended RVU: 17.00

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

<table>
<thead>
<tr>
<th><strong>RUC Meeting Date</strong> (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>49X05</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>1950</td>
</tr>
<tr>
<td><strong>Resp N:</strong></td>
<td>40</td>
</tr>
</tbody>
</table>

### Description of Sample:
Random from membership databases

<table>
<thead>
<tr>
<th><strong>Variable</strong></th>
<th><strong>Low</strong></th>
<th><strong>25th pctl</strong></th>
<th><strong>Median</strong></th>
<th><strong>75th pctl</strong></th>
<th><strong>High</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>1.00</td>
<td>5.00</td>
<td>10.00</td>
<td>20.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>10.00</td>
<td>14.88</td>
<td>17.00</td>
<td>19.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td>40.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td>90.00</td>
<td>120.00</td>
<td>151.00</td>
<td>240.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>20.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Post Operative Visits

<table>
<thead>
<tr>
<th><strong>Variable</strong></th>
<th><strong>Total Min</strong></th>
<th><strong>CPT Code</strong></th>
<th><strong>Number of Visits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>40.00</td>
<td>99231x</td>
<td>0.00 99232x</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x</td>
<td>0.00 99239x</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x</td>
<td>0.00 12x</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00 55x</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00 99225x</td>
</tr>
</tbody>
</table>

*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**

<table>
<thead>
<tr>
<th><strong>Variable</strong></th>
<th><strong>Recommended Physician Work RVU:</strong></th>
<th>14.88</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT Code:</strong></td>
<td>49X05</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Variable</strong></th>
<th><strong>Recommended Pre-Service Time</strong></th>
<th><strong>Adjustments/Recommended Pre-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>120.00</td>
<td></td>
</tr>
</tbody>
</table>

### Immediate Post Service-Time:

<table>
<thead>
<tr>
<th><strong>Variable</strong></th>
<th><strong>Recommended Post-Service Time</strong></th>
<th><strong>Adjustments/Recommended Post-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>40.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>21813</td>
<td>000</td>
<td>17.61</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X05</th>
<th>Top Key Reference CPT Code: 21813</th>
<th>2nd Key Reference CPT Code: 11005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>70.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>120.00</td>
<td>210.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>40.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>230.00</td>
<td>310.00</td>
<td>265.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X05

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>10%</td>
<td>20%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### 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 157X1, 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
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 follow up 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 inpatient 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 – 49X05**

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 49X05 is similar to somewhat more than reference code 21813. Ref 2: The respondents indicated the intensity/complexity of survey code 49X05 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 Code: 49X05

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>230</td>
<td>70</td>
<td>120</td>
<td>40</td>
<td>99232</td>
<td></td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 61645 and 93591, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>61645</td>
<td>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)</td>
<td>15.00</td>
<td>0.121</td>
<td>0.062</td>
<td>241</td>
<td>58</td>
<td>100</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>230</td>
<td>70</td>
<td>120</td>
<td>40</td>
<td>99232</td>
<td></td>
</tr>
<tr>
<td>93591</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve</td>
<td>17.97</td>
<td>0.135</td>
<td>0.086</td>
<td>208</td>
<td>58</td>
<td>120</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

![Recommended RVW vs Total Time](Recommended_RVV_Ws_Total_Time.png)

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
</tbody>
</table>
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 49X01-49X14 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.

--

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCR</th>
<th>REC</th>
<th>RVW</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>-24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td></td>
<td>0.084</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td></td>
<td>0.113</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td></td>
<td>0.105</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td></td>
<td>0.123</td>
<td>0.063</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td></td>
<td>0.120</td>
<td>0.065</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td></td>
<td>0.101</td>
<td>0.062</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td></td>
<td>0.102</td>
<td>0.063</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td>1</td>
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<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Paraostomal, Reduc</td>
<td>15.50</td>
<td></td>
<td>0.107</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td></td>
<td>0.121</td>
<td>0.074</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td></td>
<td>0.123</td>
<td>0.074</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td></td>
<td>0.109</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td></td>
<td>0.101</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td></td>
<td>0.106</td>
<td>0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Paraostomal, I/S</td>
<td>20.25</td>
<td></td>
<td>0.113</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td></td>
<td>0.115</td>
<td>0.073</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td></td>
<td>0.127</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td></td>
<td>0.117</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
</tbody>
</table>

* 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.
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.

<table>
<thead>
<tr>
<th>Specialty general surgery</th>
<th>How often?</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty colorectal surgery</td>
<td>How often?</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
</table>
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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>1972</td>
<td>90.00 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>110</td>
<td>5.02 %</td>
</tr>
<tr>
<td>Other Surgery</td>
<td>110</td>
<td>5.02 %</td>
</tr>
</tbody>
</table>

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

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**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,
### AMERICAN MEDICAL ASSOCIATION SPECIALTY SOCIETY RVS UPDATE PROCESS
### SUMMARY OF RECOMMENDATION

<table>
<thead>
<tr>
<th>CPT Code: 49X06</th>
<th>Tracking Number</th>
<th>C7</th>
<th>Original Specialty Recommended RVU: 24.24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Period: 000</td>
<td>Current Work RVU:</td>
<td></td>
<td>Presented Recommended RVU: 24.24</td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 95%</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(les):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X06</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>40</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
</tr>
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<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>2.00</td>
<td>6.00</td>
<td>11.00</td>
<td>70.00</td>
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<tr>
<td>Survey RVW:</td>
<td>14.00</td>
<td>17.94</td>
<td>20.00</td>
<td>24.24</td>
<td>40.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
<td>45.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>90.00</td>
<td>139.00</td>
<td>160.00</td>
<td>189.00</td>
<td>270.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Critical Care time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>55.00</td>
<td>99231x 0.00 99232x 0.00 99233x 1.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:** 49X06  **Recommended Physician Work RVU:** 20.00

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>3.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>160.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>25.00</td>
<td>33.00</td>
<td>-8.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>55.00</td>
<td>99231x 0.00 99232x 0.00 99233x 1.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

** 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: **

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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: **

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>61624</td>
<td>000</td>
<td>20.12</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, inaprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>0.00</td>
<td>RUC Time</td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X06</th>
<th>Top Key Reference CPT Code: 11005</th>
<th>2nd Key Reference CPT Code: 61624</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>60.00</td>
<td>95.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>160.00</td>
<td>120.00</td>
<td>232.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>25.00</td>
<td>30.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>55.00</td>
<td>55.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>310.00</td>
<td>265.00</td>
<td>362.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>0%</td>
<td>90%</td>
</tr>
<tr>
<td>Technical Skill/Physical Effort</td>
<td>Less</td>
<td>Identical</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>Technical skill required</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
<td></td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
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<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
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<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
<td>44%</td>
<td>44%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
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<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>11%</td>
<td>0%</td>
<td>89%</td>
</tr>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>11%</td>
<td>0%</td>
<td>89%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>11%</td>
<td>89%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 157X1, 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 inpatient 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 – 49X06

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 49X06 is somewhat/much more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49X06 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td>99233</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>33745</td>
<td>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</td>
<td>20.00</td>
<td>0.192</td>
<td>0.097</td>
<td>207</td>
<td>55</td>
<td>92</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>93590</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>21.70</td>
<td>0.148</td>
<td>0.097</td>
<td>223</td>
<td>58</td>
<td>135</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td>99233</td>
</tr>
<tr>
<td>33477</td>
<td>Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed</td>
<td>25.00</td>
<td>0.129</td>
<td>0.091</td>
<td>276</td>
<td>63</td>
<td>180</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>33978</td>
<td>Removal of ventricular assist device; extracorporeal, biventricular</td>
<td>25.00</td>
<td>0.109</td>
<td>0.070</td>
<td>355</td>
<td>95</td>
<td>200</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

**Relativity Assessment**

**Recommended RVW vs Total Time**

The chart below that compares the recommended RVW and total time shows good correlation.
CPT Code: 49X06

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>25th</td>
<td>12.00</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>15.50</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>median</td>
<td>16.65</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>median</td>
<td>17.00</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>median</td>
<td>18.50</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>median</td>
<td>18.53</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>75th</td>
<td>20.25</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>75th</td>
<td>24.24</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>75th</td>
<td>25.00</td>
</tr>
</tbody>
</table>

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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>2021 Formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, Vs, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, Vs, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>1</td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
</tbody>
</table>
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
CPT Code: 49X06

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Rarely</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>755</td>
<td>89.98 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>42</td>
<td>5.00 %</td>
</tr>
<tr>
<td>Other Surgery</td>
<td>42</td>
<td>5.00 %</td>
</tr>
</tbody>
</table>

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
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
CPT Code: 49X07  
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION  

CPT Code: 49X07  
Tracking Number C8  
Original Specialty Recommended RVU: 7.75  
Presented Recommended RVU: 7.75  
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 mid-epigastric 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: 49X07

Sample Size: 1950  Resp N: 41

Description of Sample: random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>5.45</td>
<td>7.75</td>
<td>11.00</td>
<td>12.03</td>
<td>18.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td>45.00</td>
<td>60.00</td>
<td>63.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time: 20.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: 49X07  Recommended Physician Work RVU: 7.75

| 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 |

Immediate Post Service-Time: 20.00  33.00  -13.00

Specialty Society Recommended Data

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
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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>37225</td>
<td>000</td>
<td>11.75</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>49013</td>
<td>000</td>
<td>8.35</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>52353</td>
<td>000</td>
<td>7.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>52356</td>
<td>000</td>
<td>8.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

**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)

<table>
<thead>
<tr>
<th>CPT Code: 49X07</th>
<th>Top Key Reference Code: 37225</th>
<th>2nd Key Reference Code: 49013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>55.00</td>
<td>38.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>118.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>20.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>135.00</td>
<td>186.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>29%</td>
<td>14%</td>
</tr>
</tbody>
</table>
**Physical effort required**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>14%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>71%</td>
<td>14%</td>
</tr>
</tbody>
</table>

- 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

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<tbody>
<tr>
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**Survey Code Compared to 2nd Key Reference Code**

<table>
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**Overall intensity/complexity**

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<th>Much More</th>
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<tbody>
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<td>20%</td>
<td>60%</td>
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</tbody>
</table>

**Mental Effort and Judgment**

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<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

- 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

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<thead>
<tr>
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</thead>
<tbody>
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**Technical Skill/Physical Effort**

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<tbody>
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</table>

- Technical skill required
- Physical effort required

<table>
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<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
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<td>20%</td>
<td>80%</td>
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**Psychological Stress**

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<tbody>
<tr>
<td>40%</td>
<td>0%</td>
<td>60%</td>
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</tbody>
</table>

- 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

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 classify procedures performed in the facility (i.e., 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 (e.g., 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 (e.g., 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 157X1, 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 inpatient 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 – 49X07**

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 49X07 is similar to reference code 37225. Ref 2: The respondents indicated the intensity/complexity of survey code 49X07 is somewhat more than reference code 49013.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>52353</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)</td>
<td>7.50</td>
<td>0.101</td>
<td>0.056</td>
<td>133</td>
<td>53</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>52356</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)</td>
<td>8.00</td>
<td>0.110</td>
<td>0.060</td>
<td>133</td>
<td>53</td>
<td>60</td>
<td>20</td>
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</tbody>
</table>

**Other Code Comparison**

Codes 37211 and 43210, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.
CPT Code: 49X07

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>37211</td>
<td>Transcatheter therapy, arterial infusion for</td>
<td>7.75</td>
<td>0.105</td>
<td>0.061</td>
<td>128</td>
<td>38</td>
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<td>30</td>
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<td></td>
<td>thrombolysis other than coronary or intracranial,</td>
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<td></td>
<td>any method, including radiological supervision and</td>
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<tr>
<td></td>
<td>interpretation, initial treatment day</td>
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<td></td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>43210</td>
<td>Esophagogastroduodenoscopy, flexible, transoral;</td>
<td>7.75</td>
<td>0.100</td>
<td>0.052</td>
<td>148</td>
<td>58</td>
<td>60</td>
<td>30</td>
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<tr>
<td></td>
<td>with esophago gastric fundoplasty, partial or</td>
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<td></td>
<td>complete, includes duodenoscopy when performed</td>
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</tr>
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</table>

**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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
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<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>25th</td>
<td>12.00</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>15.50</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>median</td>
<td>16.65</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>median</td>
<td>17.00</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>median</td>
<td>18.50</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>median</td>
<td>18.53</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>75th</td>
<td>20.25</td>
</tr>
</tbody>
</table>
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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm</th>
<th>Post</th>
<th>-33</th>
<th>-32</th>
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<tr>
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<td>WPUT</td>
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<td>108</td>
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<td>0.123</td>
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<td>113</td>
<td>55</td>
<td>77</td>
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<td>10.79</td>
<td>0.120</td>
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<td>0.062</td>
<td>113</td>
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<tr>
<td>49X09</td>
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<td>0.060</td>
<td>145</td>
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<td>49X04</td>
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<td>0.121</td>
<td>0.074</td>
<td>0.097</td>
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<td>245</td>
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<tr>
<td>49X05</td>
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<td>0.074</td>
<td>0.098</td>
<td>0.068</td>
<td>250</td>
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</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>0.093</td>
<td>0.067</td>
<td>275</td>
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<td>0.101</td>
<td>0.064</td>
<td>0.086</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
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<td>0.069</td>
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<td>0.069</td>
<td>40</td>
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<tr>
<td>49X14</td>
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<td>0.071</td>
<td>0.099</td>
<td>0.071</td>
<td>285</td>
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<tr>
<td>99285</td>
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<td>24.24</td>
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<td>49X12</td>
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<td>0.117</td>
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<td></td>
<td>inpatient</td>
</tr>
</tbody>
</table>

* 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.
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty general surgery</td>
<td>Rarely</td>
</tr>
<tr>
<td>Specialty colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty General Surgery</td>
<td>1478</td>
<td>90.01 %</td>
</tr>
<tr>
<td>Specialty colorectal surgery</td>
<td>82</td>
<td>4.99 %</td>
</tr>
<tr>
<td>Specialty Other Surgery</td>
<td>82</td>
<td>4.99 %</td>
</tr>
</tbody>
</table>

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
CPT Code: 49X08

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X08 Tracking Number C9 Original Specialty Recommended RVU: 10.79
Global Period: 000 Current Work RVU: RUC Recommended RVU: 10.79
Presented 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
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**Presenter(s):** Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS

**Specialty Society(s):** ACS, SAGES, ASCRS

**CPT Code:** 49X08

**Sample Size:** 1950 **Resp N:** 41

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pct</th>
<th>Median*</th>
<th>75th pct</th>
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<tr>
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<td>7.00</td>
<td>10.79</td>
<td>14.00</td>
<td>17.50</td>
<td>23.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
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<tr>
<td>Pre-Service Positioning Time:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
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</tr>
<tr>
<td>Intra-Service Time:</td>
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<td>65.00</td>
<td>75.00</td>
<td>90.00</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 20.00

**Post Operative Visits Total Min**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s): 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s): 20.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt: 0.00</td>
</tr>
<tr>
<td>Office time/visit(s): 0.00</td>
</tr>
<tr>
<td>Prolonged Services: 0.00</td>
</tr>
<tr>
<td>Sub Obs Care: 0.00</td>
</tr>
</tbody>
</table>

**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

| 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 |

**9B General Anes or Complex Regional Blk/Cmplx Proc**

| Pre-Service Evaluation 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 0.00  99239x 0.00  99238x 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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>21811</td>
<td>000</td>
<td>10.79</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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.

**Most Recent MPC CPT Code 1**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>000</td>
<td>10.42</td>
<td>14,028</td>
</tr>
</tbody>
</table>

**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

**Most Recent MPC CPT Code 2**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>12,731</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Number of respondents who choose Top Key Reference Code:</th>
<th>6</th>
<th>% of respondents: 14.6 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents who choose 2nd Key Reference Code:</td>
<td>5</td>
<td>% of respondents: 12.1 %</td>
</tr>
</tbody>
</table>

**TIME ESTIMATES (Median)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X08</th>
<th>Top Key Reference CPT Code: 21811</th>
<th>2nd Key Reference CPT Code: 11005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>60.00</td>
<td>70.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>75.00</td>
<td>120.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>165.00</td>
<td>220.00</td>
<td>265.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>33%</td>
<td>17%</td>
<td>33%</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical effort</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>60%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>20%</td>
<td>0%</td>
<td>80%</td>
</tr>
<tr>
<td>Physical effort</td>
<td>0%</td>
<td>80%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### 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—the 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 classify 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 157X1, 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 follow up 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 inpatient 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.

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**Recommendation – 49X08**

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 not to 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.

**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 49X08 is somewhat more than reference code 21811. Ref 2: The respondents indicated the intensity/complexity of survey code 49X08 is somewhat more than reference code 11005.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>INWPUT</th>
<th>WPPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>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</td>
<td>10.42</td>
<td>0.104</td>
<td>0.074</td>
<td>141</td>
<td>31</td>
<td>90</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X08

**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**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
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</thead>
<tbody>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>165</td>
<td>60</td>
<td>75</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Code Comparison**

Codes 92920 and 92924, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>92920</td>
<td>Percutaneous transluminal coronary angioplasty; single major coronary artery or branch</td>
<td>9.85</td>
<td>0.126</td>
<td>0.078</td>
<td>127</td>
<td>29</td>
<td>68</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>165</td>
<td>60</td>
<td>75</td>
<td>30</td>
<td></td>
<td>9231</td>
</tr>
<tr>
<td>92924</td>
<td>Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch</td>
<td>11.74</td>
<td>0.125</td>
<td>0.082</td>
<td>143</td>
<td>29</td>
<td>84</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relativity Assessment**

*Recommended RVW vs Total Time*

The chart below that compares the recommended RVW and total time shows good correlation.

![Recommended RVW vs Total Time](Image)

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>108</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>143</td>
</tr>
</tbody>
</table>
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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33-26</th>
<th>-32-25</th>
<th>-31-24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084 0.053</td>
<td>0.089 0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113 0.058</td>
<td>0.079 0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105 0.057</td>
<td>0.075 0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123 0.063</td>
<td>0.085 0.059</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120 0.065</td>
<td>0.088 0.062</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101 0.062</td>
<td>0.076 0.058</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102 0.063</td>
<td>0.078 0.060</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107 0.066</td>
<td>0.089 0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121 0.074</td>
<td>0.097 0.068</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123 0.074</td>
<td>0.098 0.068</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109 0.067</td>
<td>0.093 0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101 0.064</td>
<td>0.086 0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106 0.069</td>
<td>0.098 0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113 0.071</td>
<td>0.099 0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115 0.073</td>
<td>0.080 0.073</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127 0.078</td>
<td>0.113 0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117 0.075</td>
<td>0.104 0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>Rarely</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>945 90.00%</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>945 90.00%</td>
<td></td>
</tr>
</tbody>
</table>
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

**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
CPT Code: 49X09

Tracking Number: C10

CPT Descriptor: Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); 3 cm to 10 cm, reducible.

Original Specialty Recommended RVU: 12.00
Presented Recommended RVU: 12.00
RUC Recommended RVU: 12.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

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%

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.

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.

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:** 49X09

**Sample Size:** 1950  |  **Resp N:** 43

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>8.50</td>
<td>12.00</td>
<td>15.00</td>
<td>17.75</td>
<td>22.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td>35.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>60.00</td>
<td>83.00</td>
<td>100.00</td>
<td>123.00</td>
<td>270.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 20.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
<td>99292x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>20.00</td>
<td>99231x</td>
<td>1.00</td>
<td>99232x</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x</td>
<td>0.00</td>
<td>99239x</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x</td>
<td>0.00</td>
<td>12x</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
<td>55x</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
<td>99225x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>Recommended Physician Work RVU: 12.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>35.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>10.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>100.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30.00</td>
<td>33.00</td>
<td>-3.00</td>
</tr>
</tbody>
</table>
### CPT Code: 49X09

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

#### 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11006</td>
<td>000</td>
<td>13.10</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

#### Most Recent

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>000</td>
<td>10.42</td>
<td>RUC Time</td>
<td>14,028</td>
</tr>
</tbody>
</table>

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

#### Most Recent

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
</table>
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X09</th>
<th>Top Key Reference CPT Code: 11006</th>
<th>2nd Key Reference CPT Code: 11005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>60.00</td>
<td>65.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>100.00</td>
<td>120.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>55.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>190.00</td>
<td>270.00</td>
<td>265.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
<td>71%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>29%</td>
<td>14%</td>
<td>57%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>14%</td>
<td>0%</td>
<td>86%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>14%</td>
<td>43%</td>
<td>43%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
<td>86%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>14%</td>
<td>14%</td>
<td>71%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>43%</td>
<td>57%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

---

**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 laparoscopic/robotic under pneumoperitoneum.

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 157X1, 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, 49564, 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 inpatient 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.

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**Recommendation – 49X09**

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 49X09 is somewhat more than reference code 11006. Ref 2: The respondents indicated the intensity/complexity of survey code 49X09 is somewhat more than reference code 11005.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>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</td>
<td>10.42</td>
<td>0.104</td>
<td>0.074</td>
<td>141</td>
<td>31</td>
<td>90</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X09

49X09 Recurrent, Reduc, 3-10cm

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

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

Other Code Comparison

Codes 92924 and 37230, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>92924</td>
<td>Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch</td>
<td>11.74</td>
<td>0.125</td>
<td>0.082</td>
<td>143</td>
<td>29</td>
<td>84</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>190</td>
<td>60</td>
<td>100</td>
<td>30</td>
<td>99234</td>
</tr>
<tr>
<td>37230</td>
<td>Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>13.55</td>
<td>0.101</td>
<td>0.072</td>
<td>188</td>
<td>38</td>
<td>120</td>
<td>30</td>
<td>99291</td>
</tr>
</tbody>
</table>

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

![Recommended RVW vs Total Time](chart.png)

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>108</td>
</tr>
</tbody>
</table>
### CPT Code: 49X09

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Percentile</th>
<th>Base Value</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
<td>143</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
<td>165</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
<td>175</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>25th</td>
<td>12.00</td>
<td>190</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>15.50</td>
<td>235</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>median</td>
<td>16.65</td>
<td>225</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>median</td>
<td>17.00</td>
<td>230</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>median</td>
<td>18.50</td>
<td>275</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>median</td>
<td>18.53</td>
<td>288</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>75th</td>
<td>20.25</td>
<td>285</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>75th</td>
<td>24.24</td>
<td>310</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>75th</td>
<td>25.00</td>
<td>335</td>
</tr>
</tbody>
</table>

**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, it has become difficult to compare IWPUT (and WPUT) 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.

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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33 -26</th>
<th>-32 -25</th>
<th>-31 -24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>0.089</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>same day</td>
<td></td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>0.079</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td>same day</td>
<td></td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>0.075</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td>same day</td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>0.085</td>
<td>0.059</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>0.088</td>
<td>0.062</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>0.076</td>
<td>0.058</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>0.078</td>
<td>0.060</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>0.089</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td>inpatient</td>
<td></td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>0.097</td>
<td>0.068</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>0.098</td>
<td>0.068</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>0.093</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td>inpatient</td>
<td></td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>0.086</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td>inpatient</td>
<td></td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106</td>
<td>0.069</td>
<td>0.098</td>
<td>0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>0.099</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td>inpatient</td>
<td></td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115</td>
<td>0.073</td>
<td>0.080</td>
<td>0.073</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>0.113</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td>inpatient</td>
<td></td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>0.104</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td>inpatient</td>
<td></td>
</tr>
</tbody>
</table>

* 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.
CPT Code: 49X09

**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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>general surgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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 | %
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 49X09

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>4118</td>
<td>90.01 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>229</td>
<td>5.00 %</td>
</tr>
<tr>
<td>Other Surgery</td>
<td>229</td>
<td>5.00 %</td>
</tr>
</tbody>
</table>

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: 49X10  Tracking Number: C11  Original Specialty Recommended RVU: 18.50
Global Period: 000  Current Work RVU:  RUC Recommended RVU: 16.50

Presented Recommended RVU: 18.50

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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X10</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>43</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>3.00</td>
<td>5.00</td>
<td>13.00</td>
<td>130.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>10.00</td>
<td>16.50</td>
<td>18.50</td>
<td>22.28</td>
<td>28.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>70.00</td>
<td>120.00</td>
<td>140.00</td>
<td>190.00</td>
<td>360.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits Total Min**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Critical Care time/visit(s):</th>
<th>Other Hospital time/visit(s):</th>
<th>Discharge Day Mgmt:</th>
<th>Office time/visit(s):</th>
<th>Prolonged Services:</th>
<th>Sub Obs Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>40.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>99291x 0.00</td>
<td>99231x 1.00</td>
<td>99238x 0.00</td>
<td>99211x 0.00</td>
<td>99354x 0.00</td>
<td>99224x 0.00</td>
</tr>
<tr>
<td></td>
<td>99292x 0.00</td>
<td>99232x 1.00</td>
<td>99239x 0.00</td>
<td>99212x 0.00</td>
<td>99253x 0.00</td>
<td>99225x 0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>Recommended Physician Work RVU: 16.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>3.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>140.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>25.00</td>
<td>33.00</td>
<td>-8.00</td>
</tr>
</tbody>
</table>
**CPT Code: 49X10**

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>40.00</td>
<td>99231x 0.00 99232x 1.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>33891</td>
<td>000</td>
<td>20.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>21813</td>
<td>000</td>
<td>17.61</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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  %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 49X10</th>
<th>Top Key Reference CPT Code: 33891</th>
<th>2nd Key Reference CPT Code: 21813</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>110.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>140.00</td>
<td>173.00</td>
<td>210.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>25.00</td>
<td>40.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>40.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
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<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>275.00</td>
<td>323.00</td>
<td>310.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>18%</td>
<td>18%</td>
<td>36%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
<td>18%</td>
<td>36%</td>
<td>45%</td>
</tr>
<tr>
<td>Technical Skill/Physical Effort</td>
<td>Less</td>
<td>Identical</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>Technical skill required</td>
<td>18%</td>
<td>36%</td>
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<tr>
<td>Physical effort required</td>
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<table>
<thead>
<tr>
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<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>45%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>56%</td>
<td>11%</td>
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<th>Identical</th>
<th>More</th>
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<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>44%</td>
<td>56%</td>
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<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>44%</td>
<td>56%</td>
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</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
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<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 157X1, 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

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**CPT Code: 49X10**
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 follow up 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 inpatient 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 – 49X10**

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 49X10 is similar to somewhat more than reference code 33891. Ref 2: The respondents indicated the intensity/complexity of survey code 49X10 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.
radiological supervision and interpretation, intraprocedural roadmapping, and imaging
guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic
extravasation

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
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<tbody>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td>99232</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
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</thead>
<tbody>
<tr>
<td>33956</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
<td>16.00</td>
<td>0.108</td>
<td>0.064</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td>30</td>
<td>99291</td>
<td></td>
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<tr>
<td>93591</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve</td>
<td>17.97</td>
<td>0.135</td>
<td>0.086</td>
<td>208</td>
<td>58</td>
<td>120</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td>99232</td>
<td></td>
</tr>
<tr>
<td>33745</td>
<td>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</td>
<td>20.00</td>
<td>0.192</td>
<td>0.097</td>
<td>207</td>
<td>55</td>
<td>92</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93590</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>21.70</td>
<td>0.148</td>
<td>0.097</td>
<td>223</td>
<td>58</td>
<td>135</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
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<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm 25th</td>
<td>6.27</td>
<td>108</td>
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<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm 25th</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm 25th</td>
<td>9.00</td>
<td>143</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm 25th</td>
<td>10.79</td>
<td>165</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm 25th</td>
<td>10.80</td>
<td>175</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm 25th</td>
<td>12.00</td>
<td>190</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc median</td>
<td>15.50</td>
<td>235</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm median</td>
<td>16.65</td>
<td>225</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm median</td>
<td>17.00</td>
<td>230</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm median</td>
<td>18.50</td>
<td>275</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm median</td>
<td>18.53</td>
<td>288</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S 75th</td>
<td>20.25</td>
<td>285</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm 75th</td>
<td>24.24</td>
<td>310</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm 75th</td>
<td>25.00</td>
<td>335</td>
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</table>

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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>RVW</td>
<td>IWPUT</td>
<td>WPUT</td>
<td>WPUT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>0.089</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>same day</td>
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<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>0.079</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td>same day</td>
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<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>0.075</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, V/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>0.085</td>
<td>0.059</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>1 overnight</td>
<td></td>
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<tr>
<td>49X08</td>
<td>Recurrent, V/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>0.088</td>
<td>0.062</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>1 overnight</td>
<td></td>
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<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>0.076</td>
<td>0.058</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>1 overnight</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Rate</td>
<td>Work RVU</td>
<td>Pre RVU</td>
<td>Intr RVU</td>
<td>Post RVU</td>
<td>Global Period</td>
<td>WRT</td>
<td>HCPCS</td>
<td>Modality</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>----------------------------------</td>
<td>-------</td>
<td>----------</td>
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<tr>
<td>49X10</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>0.078</td>
<td>0.060</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td>overnight</td>
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<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>0.089</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
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<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>0.097</td>
<td>0.068</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td>overnight</td>
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<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>0.098</td>
<td>0.068</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>0.093</td>
<td>0.067</td>
<td>275</td>
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<td>140</td>
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<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>0.086</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
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</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106</td>
<td>0.069</td>
<td>0.098</td>
<td>0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
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<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>0.099</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
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</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115</td>
<td>0.073</td>
<td>0.080</td>
<td>0.073</td>
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<td>9</td>
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<td>16</td>
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<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>0.113</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
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</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>0.104</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td>inpatient</td>
<td></td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>3308</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>184</td>
<td>5.00%</td>
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</tr>
<tr>
<td>Other Surgery</td>
<td>184</td>
<td>5.00%</td>
<td></td>
</tr>
</tbody>
</table>

Do many physicians perform this service across the United States? Yes

---

**Beronson-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
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
CPT Code: 49X11  
Tracking Number C12  
Original Specialty Recommended RVU: 18.53  
Presented Recommended RVU: 18.53  
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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 90%</td>
</tr>
</tbody>
</table>

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 falcial 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(les):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
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</tr>
<tr>
<td>Sample Size:</td>
<td>1950</td>
</tr>
<tr>
<td>Resp N:</td>
<td>42</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>2.00</td>
<td>7.00</td>
<td>12.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>11.50</td>
<td>16.03</td>
<td>18.53</td>
<td>22.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>70.00</td>
<td>120.00</td>
<td>150.00</td>
<td>178.00</td>
<td>300.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>28.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>99231x 0.00 99232x 1.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

**CPT Code:** 49X11  
**Recommended Physician Work RVU:** 16.97

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>40.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>3.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
<td>-5.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>150.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>28.00</td>
<td>33.00</td>
<td>-5.00</td>
</tr>
</tbody>
</table>
CPT Code: 49X11

### Post-Operative Visits

<table>
<thead>
<tr>
<th>Time/visit(s)</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital</td>
<td>40.00</td>
<td>99231x 0.00 99232x 1.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

### 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**: 11005
  - **Global**: 000
  - **Work RVU**: 14.24
  - **Time Source**: 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**: 11006
  - **Global**: 000
  - **Work RVU**: 13.10
  - **Time Source**: 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**: 37244
  - **Global**: 000
  - **Work RVU**: 13.75
  - **Time Source**: RUC Time
  - **Medicare Utilization**: 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**: 000
  - **Global**: 000
  - **Work RVU**: 0.00
  - **Time Source**: RUC Time

  CPT Descriptor 2: [Other Reference CPT Code]

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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 49X11</th>
<th>Top Key Reference CPT Code: 11005</th>
<th>2nd Key Reference CPT Code: 11006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>60.00</td>
<td>65.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>150.00</td>
<td>120.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>28.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>40.00</td>
<td>55.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>288.00</td>
<td>265.00</td>
<td>270.00</td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>11%</td>
<td>44%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11%</td>
<td>33%</td>
<td>56%</td>
</tr>
</tbody>
</table>

- 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
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22%</td>
<td>33%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 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 157X1, 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
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 inpatient 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 – 49X11**

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 49X11 is somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49X11 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWP</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td>99232</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWP</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>33956</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
<td>16.00</td>
<td>0.108</td>
<td>0.064</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td>30</td>
<td>99291</td>
</tr>
<tr>
<td>93591</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve</td>
<td>17.97</td>
<td>0.135</td>
<td>0.086</td>
<td>208</td>
<td>58</td>
<td>120</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td>99232</td>
</tr>
<tr>
<td>33745</td>
<td>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</td>
<td>20.00</td>
<td>0.192</td>
<td>0.097</td>
<td>207</td>
<td>55</td>
<td>92</td>
<td>60</td>
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<tr>
<td>93590</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>21.70</td>
<td>0.148</td>
<td>0.097</td>
<td>223</td>
<td>58</td>
<td>135</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>25th</td>
<td>12.00</td>
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<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>15.50</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>median</td>
<td>16.65</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>median</td>
<td>17.00</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>median</td>
<td>18.50</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>median</td>
<td>18.53</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>75th</td>
<td>20.25</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>75th</td>
<td>24.24</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>75th</td>
<td>25.00</td>
</tr>
</tbody>
</table>

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 49X01-49X14 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.

**2021 Full Value Formula: IWPUT calculation based on pre-service and immediate post-service time intensity of 0.043 -33 -26 -32 -25 -31 -24. WPUT calculation equal to total time (including discounted postop visit time not shown on table) divided by work.

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
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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty General Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty Colorectal Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty Other Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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
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
CPT Code: 49X12

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X12  Tracking Number  C13  Original Specialty Recommended RVU: 25.00
Global Period: 000  Current Work RVU:  RUC Recommended RVU: 24.00
Presented Recommended RVU: 25.00

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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
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<td>CPT Code:</td>
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<td>42</td>
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Description of Sample: random from membership databases

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<th>Median*</th>
<th>75th pctl</th>
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</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>100.00</td>
<td>175.00</td>
<td>180.00</td>
<td>208.00</td>
<td>330.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post Operative Visits

<table>
<thead>
<tr>
<th>Critical Care time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
<td>99292x 0.00</td>
</tr>
<tr>
<td>55.00</td>
<td>99231x</td>
<td>0.00</td>
<td>99232x 0.00</td>
</tr>
<tr>
<td>0.00</td>
<td>99238x</td>
<td>0.00</td>
<td>99239x 0.00</td>
</tr>
<tr>
<td>0.00</td>
<td>99211x</td>
<td>0.00</td>
<td>12x 0.00</td>
</tr>
<tr>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
<td>55x 0.00</td>
</tr>
<tr>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
<td>99225x 0.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>49X12</th>
<th>Recommended Physician Work RVU: 24.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>180.00</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>30.00</td>
<td>33.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>55.00</td>
<td>99231x 0.00 99232x 0.00 99233x 1.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.0 99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>61624</td>
<td>000</td>
<td>20.12</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>21813</td>
<td>000</td>
<td>17.61</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>RUC Time</td>
<td></td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X12</th>
<th>Top Key Reference CPT Code: 61624</th>
<th>2nd Key Reference CPT Code: 21813</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>95.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>180.00</td>
<td>232.00</td>
<td>210.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>30.00</td>
<td>35.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>55.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>335.00</td>
<td>362.00</td>
<td>310.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**  
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>6%</td>
<td>19%</td>
<td>25%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>25%</td>
<td>69%</td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13%</td>
<td>19%</td>
<td>69%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>13%</td>
<td>88%</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>25%</td>
<td>69%</td>
</tr>
</tbody>
</table>

- 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

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

- 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

---

**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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**Background**

**RAW Screen**
CPT Code: 49X12

CPT 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 (i.e., 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 (e.g., 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 (e.g., 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 157X1, 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 inpatient 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 procedures 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 – 49X12

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 49X12 is somewhat more than reference code 61624. Ref 2: The respondents indicated the intensity/complexity of survey code 49X12 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IINPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IPT</th>
<th>WP</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>93590</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>21.70</td>
<td>0.148</td>
<td>0.097</td>
<td>223</td>
<td>58</td>
<td>135</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>33477</td>
<td>Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed</td>
<td>25.00</td>
<td>0.129</td>
<td>0.091</td>
<td>276</td>
<td>63</td>
<td>180</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td>99233</td>
</tr>
<tr>
<td>33978</td>
<td>Removal of ventricular assist device; extracorporeal, biventricular</td>
<td>25.00</td>
<td>0.109</td>
<td>0.070</td>
<td>355</td>
<td>95</td>
<td>200</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Desc</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>108</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>143</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>165</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>175</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>190</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>median</td>
<td>235</td>
</tr>
</tbody>
</table>
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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>Pre</th>
<th>Intra Post</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>-32</th>
<th>-31</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td></td>
<td>1.60</td>
<td></td>
<td>0.084</td>
<td>0.053</td>
<td></td>
<td></td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td></td>
<td></td>
<td>0.113</td>
<td>0.058</td>
<td></td>
<td></td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td></td>
<td></td>
<td>0.105</td>
<td>0.057</td>
<td></td>
<td></td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td></td>
<td></td>
<td>0.123</td>
<td>0.063</td>
<td></td>
<td></td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td></td>
<td></td>
<td>0.120</td>
<td>0.065</td>
<td></td>
<td></td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td></td>
<td></td>
<td>0.101</td>
<td>0.062</td>
<td></td>
<td></td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td></td>
<td></td>
<td>0.102</td>
<td>0.063</td>
<td></td>
<td></td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td></td>
<td></td>
<td>0.107</td>
<td>0.066</td>
<td></td>
<td></td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td></td>
<td></td>
<td>0.121</td>
<td>0.074</td>
<td></td>
<td></td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td></td>
<td></td>
<td>0.123</td>
<td>0.074</td>
<td></td>
<td></td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td></td>
<td>overnight</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td></td>
<td></td>
<td>0.109</td>
<td>0.067</td>
<td></td>
<td></td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td></td>
<td></td>
<td>0.101</td>
<td>0.064</td>
<td></td>
<td></td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td></td>
<td></td>
<td>0.106</td>
<td>0.069</td>
<td></td>
<td></td>
<td>60</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td></td>
<td></td>
<td>0.113</td>
<td>0.071</td>
<td></td>
<td></td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td></td>
<td></td>
<td>0.115</td>
<td>0.073</td>
<td></td>
<td></td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td></td>
<td></td>
<td>0.127</td>
<td>0.078</td>
<td></td>
<td></td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td>inpatient</td>
</tr>
</tbody>
</table>

* 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 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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty General Surgery</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Colorectal Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty Other Surgery</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
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
CPT Code: 49X13

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X13  Tracking Number  C14  Original Specialty Recommended RVU: 15.50
Global Period: 000  Current Work RVU:
Presented Recommended RVU: 15.50
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 scrub 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: 49X13

Sample Size: 1300  Resp N: 39

Description of Sample: random from membership databases

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Evaluation Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate Post Service-Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)**


<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**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

| Immediate Post Service-Time: | 25.00 | 33.00 | -8.00 |
**CPT Code: 49X13**

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>20.00</td>
<td>99231x 1.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>000</td>
<td>14.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>21813</td>
<td>000</td>
<td>17.61</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>Most Recent</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

CPT Descriptor
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.**

<table>
<thead>
<tr>
<th>Number of respondents who choose Top Key Reference Code: 7</th>
<th>% of respondents: 17.9 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents who choose 2nd Key Reference Code: 7</td>
<td>% of respondents: 17.9 %</td>
</tr>
</tbody>
</table>

**TIME ESTIMATES (Median)**

<table>
<thead>
<tr>
<th>CPT Code: 49X13</th>
<th>Top Key Reference CPT Code: 11005</th>
<th>2nd Key Reference CPT Code: 21813</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>120.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>25.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>20.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>235.00</td>
<td>265.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>29%</td>
<td>71%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29%</td>
<td>0%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>14%</td>
<td>86%</td>
</tr>
</tbody>
</table>
CPT Code: 49X13

**Physical effort required**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>29%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**Psychological Stress**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>43%</td>
<td>57%</td>
</tr>
</tbody>
</table>

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>29%</td>
<td>57%</td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>57%</td>
<td>43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>57%</td>
<td>43%</td>
</tr>
</tbody>
</table>

**Psychological Stress**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>57%</td>
<td>43%</td>
</tr>
</tbody>
</table>

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**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 157X1, 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 inpatient 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 – 49X13**

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 49X13 is similar to somewhat more than reference code 11005. Ref 2: The respondents indicated the intensity/complexity of survey code 49X13 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>INTRA</th>
<th>POST</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>235</td>
</tr>
</tbody>
</table>

**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 Code: 49X13

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTR</th>
<th>RVW</th>
<th>WPIT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD</th>
<th>E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>61645</td>
<td>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)</td>
<td>15.00</td>
<td>0.121</td>
<td>0.062</td>
<td>241</td>
<td>58</td>
<td>100</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td>99231</td>
<td></td>
</tr>
<tr>
<td>33956</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
<td>16.00</td>
<td>0.108</td>
<td>0.064</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td>30</td>
<td>99291</td>
<td></td>
</tr>
<tr>
<td>33981</td>
<td>Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump</td>
<td>16.11</td>
<td>0.108</td>
<td>0.059</td>
<td>275</td>
<td>95</td>
<td>120</td>
<td>60</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

![Recommended RVW vs Total Time](image)

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>108</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>135</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>143</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>165</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>175</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>190</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>235</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>225</td>
</tr>
</tbody>
</table>
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 49X01-49X14 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-service work for outpatients (not shown on table) has a significant impact on IWPUT and WPUT comparisons. 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. This table also shows evidence that discounting postoperative 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.

### Table: CPT Codes for Hernia Cases

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>2021 formula* IWPUT</th>
<th>2021 formula* WPUT</th>
<th>2021 full value** IWPUT</th>
<th>2021 full value** WPUT</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33</th>
<th>-32</th>
<th>-31</th>
<th>-24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084</td>
<td>0.053</td>
<td>0.089</td>
<td>0.053</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>6.27</td>
<td>0.113</td>
<td>0.058</td>
<td>0.079</td>
<td>0.058</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>7.75</td>
<td>0.105</td>
<td>0.057</td>
<td>0.075</td>
<td>0.057</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>9.00</td>
<td>0.123</td>
<td>0.063</td>
<td>0.085</td>
<td>0.059</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
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<td></td>
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<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>10.79</td>
<td>0.120</td>
<td>0.065</td>
<td>0.088</td>
<td>0.062</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
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<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Recur, 3-10cm</td>
<td>10.80</td>
<td>0.101</td>
<td>0.062</td>
<td>0.076</td>
<td>0.058</td>
<td>185</td>
<td>55</td>
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<td>20</td>
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<td></td>
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<td>same day</td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Recur, 3-10cm</td>
<td>12.00</td>
<td>0.102</td>
<td>0.063</td>
<td>0.078</td>
<td>0.060</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>same day</td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Recur</td>
<td>15.50</td>
<td>0.107</td>
<td>0.066</td>
<td>0.089</td>
<td>0.066</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
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<td></td>
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<td>inpatient</td>
</tr>
<tr>
<td>49X04</td>
<td>Initial, I/S, 3-10cm</td>
<td>16.65</td>
<td>0.121</td>
<td>0.074</td>
<td>0.097</td>
<td>0.068</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
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<td>inpatient</td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Recur, &gt; 10cm</td>
<td>17.00</td>
<td>0.123</td>
<td>0.074</td>
<td>0.098</td>
<td>0.068</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
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<td></td>
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<td>inpatient</td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, I/S, 3-10cm</td>
<td>18.50</td>
<td>0.109</td>
<td>0.067</td>
<td>0.093</td>
<td>0.067</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
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<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Recur, &gt; 10cm</td>
<td>18.53</td>
<td>0.101</td>
<td>0.064</td>
<td>0.086</td>
<td>0.064</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
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<td></td>
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<td>inpatient</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106</td>
<td>0.069</td>
<td>0.098</td>
<td>0.069</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>0.099</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115</td>
<td>0.073</td>
<td>0.080</td>
<td>0.073</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
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<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X06</td>
<td>Initial, I/S, &gt; 10cm</td>
<td>24.24</td>
<td>0.127</td>
<td>0.078</td>
<td>0.113</td>
<td>0.078</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
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<td></td>
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<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, I/S, &gt; 10cm</td>
<td>25.00</td>
<td>0.117</td>
<td>0.075</td>
<td>0.104</td>
<td>0.075</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
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<td>inpatient</td>
</tr>
</tbody>
</table>

* 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? Yes/No: 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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Service Description</th>
<th>Global Period</th>
<th>Work RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>49560</td>
<td>Repair initial incisional or ventral hernia; reducible</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49565</td>
<td>Repair recurrent incisional or ventral hernia; reducible</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49654</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49656</td>
<td>Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49659</td>
<td>Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy</td>
<td>YYY</td>
<td></td>
</tr>
<tr>
<td>49999</td>
<td>Unlisted procedure, abdomen, peritoneum and omentum</td>
<td>YYY</td>
<td></td>
</tr>
<tr>
<td>49568</td>
<td>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)</td>
<td>ZZZ</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Rarely</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>638</td>
<td>89.98 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>35</td>
<td>4.93 %</td>
</tr>
</tbody>
</table>
CPT Code: 49X13

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
CPT Code: 49X14

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49X14 Tracking Number C15
Original Specialty Recommended RVU: 20.25
Presented Recommended RVU: 20.25
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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenters</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies)</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code</td>
<td>49X14</td>
</tr>
<tr>
<td>Sample Size</td>
<td>1300</td>
</tr>
<tr>
<td>Resp N</td>
<td>39</td>
</tr>
<tr>
<td>Description of Sample</td>
<td>random from membership databases</td>
</tr>
</tbody>
</table>

#### Service Performance Rate

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>2.00</td>
<td>3.00</td>
<td>10.00</td>
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#### Survey RVW

<table>
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<th>Median*</th>
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<tbody>
<tr>
<td>10.08</td>
<td>16.00</td>
<td>18.00</td>
<td>20.25</td>
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#### Pre-Service Evaluation Time:

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<tr>
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<th>Median*</th>
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#### Pre-Service Positioning Time:

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<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Pre-Service Scrub, Dress, Wait Time:

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Intra-Service Time:

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.00</td>
<td>123.00</td>
<td>150.00</td>
<td>180.00</td>
<td>360.00</td>
</tr>
</tbody>
</table>

#### Immediate Post Service-Time:

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
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</tr>
</thead>
<tbody>
<tr>
<td>25.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Post Operative Visits

**Physician standard total minutes per E/M visit:**

- 99291 (70)
- 99292 (30)
- 99231 (20)
- 99232 (40)
- 99233 (55)
- 99240 (38)
- 99241 (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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Recommended Physician Work RVU: 18.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>150.00</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Recommended Physician Work RVU: 18.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Recommended Post-Service Time</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>25.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>40.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
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<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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</thead>
<tbody>
<tr>
<td>21813</td>
<td>000</td>
<td>17.61</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>33891</td>
<td>000</td>
<td>20.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>000</td>
<td>13.75</td>
<td>RUC Time</td>
<td>12,731</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0.00</td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

CPT Descriptor
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 49X14</th>
<th>Top Key Reference CPT Code: 21813</th>
<th>2nd Key Reference CPT Code: 33891</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>70.00</td>
<td>110.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>150.00</td>
<td>210.00</td>
<td>173.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>25.00</td>
<td>30.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>40.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>285.00</td>
<td>310.00</td>
<td>323.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>10%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>17%</td>
<td>33%</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>33%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 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*
CPT Code: 49X14

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.amcollsurg.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 157X1, 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 follow up 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 inpatient 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 procedures 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 (i.e., 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 – 49X14**

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 (e.g., 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 49X14 is similar to somewhat more than reference code 21813. Ref 2: The respondents indicated the intensity/complexity of survey code 49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>37244</td>
<td>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</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td>99232</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>I/WPUT</th>
<th>W/PUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>33745</td>
<td>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 (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt</td>
<td>20.00</td>
<td>0.192</td>
<td>0.097</td>
<td>207</td>
<td>55</td>
<td>92</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, I/S</td>
<td>20.25</td>
<td>0.113</td>
<td>0.071</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td>99232</td>
</tr>
<tr>
<td>93590</td>
<td>Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve</td>
<td>21.70</td>
<td>0.148</td>
<td>0.097</td>
<td>223</td>
<td>58</td>
<td>135</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Relativity Assessment

Recommended RVW vs Total Time

The chart below that compares the recommended RVW and total time shows good correlation.

![Recommended RVW vs Total Time Chart]

R² = 0.982

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>6.27</td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3cm</td>
<td>25th</td>
<td>7.75</td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, I/S, &lt; 3cm</td>
<td>25th</td>
<td>9.00</td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, I/S, &lt; 3cm</td>
<td>25th</td>
<td>10.79</td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>25th</td>
<td>10.80</td>
</tr>
</tbody>
</table>
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 -54% 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 49X01-49X14 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>REC RVW</th>
<th>2021 formula*</th>
<th>2021 full value**</th>
<th>Total Time</th>
<th>PRE</th>
<th>Intra</th>
<th>Imm Post</th>
<th>-33 -26</th>
<th>-32 -25</th>
<th>-31 -24</th>
<th>Facility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Low MDM</td>
<td>1.60</td>
<td>0.084 IWPUT</td>
<td>0.089 IWPUT</td>
<td>30</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>same day</td>
<td>overnight</td>
<td></td>
<td>inpatient</td>
</tr>
<tr>
<td>49X01</td>
<td>Initial, Reduc, &lt; 3 cm</td>
<td>6.27</td>
<td>0.113 IWPUT</td>
<td>0.079 IWPUT</td>
<td>108</td>
<td>43</td>
<td>45</td>
<td>20</td>
<td>same day</td>
<td></td>
<td>overnight</td>
<td></td>
</tr>
<tr>
<td>49X07</td>
<td>Recurrent, Reduc, &lt; 3 cm</td>
<td>7.75</td>
<td>0.105 IWPUT</td>
<td>0.075 IWPUT</td>
<td>135</td>
<td>55</td>
<td>60</td>
<td>20</td>
<td>same day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X02</td>
<td>Initial, IS, &lt; 3 cm</td>
<td>9.00</td>
<td>0.123 IS PUT</td>
<td>0.085 IS PUT</td>
<td>153</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td>overnight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X08</td>
<td>Recurrent, IS, &lt; 3 cm</td>
<td>10.79</td>
<td>0.120 IS PUT</td>
<td>0.088 IS PUT</td>
<td>175</td>
<td>60</td>
<td>75</td>
<td>20</td>
<td>overnight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X03</td>
<td>Initial, Reduc, 3-10cm</td>
<td>10.80</td>
<td>0.101 IS PUT</td>
<td>0.076 IS PUT</td>
<td>185</td>
<td>55</td>
<td>90</td>
<td>20</td>
<td>overnight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X09</td>
<td>Recurrent, Reduc, 3-10cm</td>
<td>12.00</td>
<td>0.102 IS PUT</td>
<td>0.078 IS PUT</td>
<td>200</td>
<td>60</td>
<td>100</td>
<td>20</td>
<td>overnight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X13</td>
<td>Parastomal, Reduc</td>
<td>15.50</td>
<td>0.107 IS PUT</td>
<td>0.089 IS PUT</td>
<td>235</td>
<td>70</td>
<td>120</td>
<td>25</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
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<tr>
<td>49X04</td>
<td>Initial, IS, 3-10cm</td>
<td>16.65</td>
<td>0.121 IS PUT</td>
<td>0.097 IS PUT</td>
<td>245</td>
<td>65</td>
<td>120</td>
<td>20</td>
<td></td>
<td>overnight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X05</td>
<td>Initial, Reduc, &gt; 10cm</td>
<td>17.00</td>
<td>0.123 IS PUT</td>
<td>0.098 IS PUT</td>
<td>250</td>
<td>70</td>
<td>120</td>
<td>20</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X10</td>
<td>Recurrent, IS, 3-10cm</td>
<td>18.50</td>
<td>0.109 IS PUT</td>
<td>0.093 IS PUT</td>
<td>275</td>
<td>70</td>
<td>140</td>
<td>25</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X11</td>
<td>Recurrent, Reduc, &gt; 10cm</td>
<td>18.53</td>
<td>0.101 IS PUT</td>
<td>0.086 IS PUT</td>
<td>288</td>
<td>70</td>
<td>150</td>
<td>28</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99284</td>
<td>Moderate MDM</td>
<td>2.74</td>
<td>0.106 IS PUT</td>
<td>0.098 IS PUT</td>
<td>40</td>
<td>6</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X14</td>
<td>Parastomal, IS</td>
<td>20.25</td>
<td>0.113 IS PUT</td>
<td>0.099 IS PUT</td>
<td>285</td>
<td>70</td>
<td>150</td>
<td>25</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99285</td>
<td>High MDM</td>
<td>4.00</td>
<td>0.115 IS PUT</td>
<td>0.080 IS PUT</td>
<td>55</td>
<td>9</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>49X06</td>
<td>Initial, IS, &gt; 10cm</td>
<td>24.24</td>
<td>0.127 IS PUT</td>
<td>0.113 IS PUT</td>
<td>310</td>
<td>70</td>
<td>160</td>
<td>25</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49X12</td>
<td>Recurrent, IS, &gt; 10cm</td>
<td>25.00</td>
<td>0.117 IS PUT</td>
<td>0.104 IS PUT</td>
<td>335</td>
<td>70</td>
<td>180</td>
<td>30</td>
<td></td>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>49561</td>
<td>Repair initial incisional or ventral hernia; incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49566</td>
<td>Repair recurrent incisional or ventral hernia; incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49655</td>
<td>Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49657</td>
<td>Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
<td></td>
</tr>
<tr>
<td>49659</td>
<td>Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy</td>
<td>YYY</td>
<td></td>
</tr>
<tr>
<td>49999</td>
<td>Unlisted procedure, abdomen, peritoneum and omentum</td>
<td>YYY</td>
<td></td>
</tr>
<tr>
<td>49568</td>
<td>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)</td>
<td>ZZZ</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty general surgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Specialty colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
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
CPT Code: 49X15  Tracking Number  C16  

Original Specialty Recommended RVU: **5.00**  
Presented Recommended RVU: **5.00**  
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>49X15</td>
</tr>
</tbody>
</table>

Sample Size: 4200  |  Resp N: 150

Description of Sample: random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
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<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>1.00</td>
<td>3.00</td>
<td>10.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>1.55</td>
<td>5.00</td>
<td>5.00</td>
<td>6.50</td>
<td>15.02</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
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<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
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<tr>
<td>Intra-Service Time:</td>
<td>15.00</td>
<td>30.00</td>
<td>45.00</td>
<td>50.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Operative Visits</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>49X15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>5.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>45.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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)**

**Specialty Society Recommended Data**

**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)

**ZZZ Global Code**

<table>
<thead>
<tr>
<th><strong>CPT Code</strong></th>
<th><strong>Recommended Physician Work RVU</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>49X15</td>
<td>5.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>45.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11008</td>
<td>ZZZ</td>
<td>5.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>35572</td>
<td>ZZZ</td>
<td>6.81</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>ZZZ</td>
<td>4.13</td>
<td>RUC Time</td>
<td>9013</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor 2

**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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 49X15</th>
<th>Top Key Reference CPT Code: 11008</th>
<th>2nd Key Reference CPT Code: 35572</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>60.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>45.00</td>
<td>60.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES (of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>67%</td>
<td>22%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>1%</td>
<td>65%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>61%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>64%</td>
<td>29%</td>
</tr>
</tbody>
</table>

- 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

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>33%</td>
<td>58%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>25%</td>
<td>67%</td>
</tr>
</tbody>
</table>

- Technical skill required
- Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>17%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>17%</td>
<td>75%</td>
</tr>
</tbody>
</table>

- 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

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 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." 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 to reach and visualize the site 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—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 157X1, 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 inpatient 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 – 49X15 (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 49X15 is similar to somewhat more than reference code 11008. Ref 2: The respondents indicated the intensity/complexity of survey code 49X15 is somewhat more than reference code 35572.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>INPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>34812</td>
<td>Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)</td>
<td>4.13</td>
<td>0.103</td>
<td>0.103</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>49X15</td>
<td>Removal of mesh</td>
<td>5.00</td>
<td>0.111</td>
<td>0.111</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

**Other Code Comparison**

Codes 57267 and 63295, which bracket the recommendation for the survey code, offer further support for the recommended work RVU.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>INPUT</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>57267</td>
<td>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)</td>
<td>4.88</td>
<td>0.108</td>
<td>0.108</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>49X15</td>
<td>Removal of mesh</td>
<td>5.00</td>
<td>0.111</td>
<td>0.111</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>63295</td>
<td>Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)</td>
<td>5.25</td>
<td>0.112</td>
<td>0.095</td>
<td>55</td>
<td>10</td>
<td>45</td>
<td>0</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global Period</th>
<th>Work RVUs</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Physician Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>49565-22</td>
<td>Repair recurrent incisional or ventral hernia; reducible</td>
<td>090</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49566-22</td>
<td>Repair recurrent incisional or ventral hernia; incarcerated or strangulated</td>
<td>090</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49656-22</td>
<td>Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible</td>
<td>090</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49657-22</td>
<td>Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated</td>
<td>090</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49569</td>
<td>Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy</td>
<td>YYY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49999</td>
<td>Unlisted procedure, abdomen, peritoneum and omentum</td>
<td>YYY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

Estimate the number of times this service might be provided nationally in a one-year period? National frequency not available

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>2638</td>
<td>90.00 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>147</td>
<td>5.01 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>2638</td>
<td>90.00 %</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>147</td>
<td>5.01 %</td>
</tr>
</tbody>
</table>
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
CPT Code: 157X1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 157X1  Tracking Number C1  Original Specialty Recommended RVU: **8.50**

Presented Recommended RVU: **8.50**

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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Charles Mabry, MD, FACS; Don Selzer, MD, FACS; Ketan Sheth, MD, FACS; Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>ACS, SAGES, ASCRS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>157X1</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>1200</td>
</tr>
<tr>
<td>Resp N:</td>
<td>36</td>
</tr>
</tbody>
</table>

**Description of Sample:** random from membership databases

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
<td>3.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>5.00</td>
<td>8.00</td>
<td>8.50</td>
<td>10.00</td>
<td>20.25</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>45.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>50.00</td>
<td>60.00</td>
<td>90.00</td>
<td>96.00</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 25.00

**Post-Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>95.00 99231x 0.00 99232x 1.00 99233x 1.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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**

| 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**

| Immediate Post Service-Time: | 25.00 | 33.00 | -8.00 |
CPT Code: 157X1

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>40.00</td>
<td>99231x 0.00 99232x 1.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>49013</td>
<td>000</td>
<td>8.35</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15273</td>
<td>000</td>
<td>3.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>7.50</td>
<td>RUC Time</td>
<td>11,180</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

**MPC CPT Code 2**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>9.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 157X1</th>
<th>Top Key Reference Code: 49013</th>
<th>2nd Key Reference Code: 15273</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>58.00</td>
<td>50.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>90.00</td>
<td>45.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>25.00</td>
<td>60.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>40.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>213.00</td>
<td>155.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>58%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>25%</td>
<td>17%</td>
<td>58%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
<td>0%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 157X1, 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."
CPT Code: 157X1

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 follow up 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 (i.e., 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 – 157X1**

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 (e.g., 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 157X1 is somewhat more than reference code 49013. Ref 2: The respondents indicated the intensity/complexity of survey code 157X1 is somewhat/much more than reference code 15273.

**MPC Code Comparison**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>WPOT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>SD E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>52353</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)</td>
<td>7.50</td>
<td>0.101</td>
<td>0.056</td>
<td>133</td>
<td>53</td>
<td>60</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>157X1</td>
<td>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</td>
<td>8.50</td>
<td>0.061</td>
<td>0.040</td>
<td>213</td>
<td>58</td>
<td>90</td>
<td>25</td>
<td>99232</td>
</tr>
<tr>
<td>36905</td>
<td>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,</td>
<td>9.00</td>
<td>0.106</td>
<td>0.071</td>
<td>126</td>
<td>31</td>
<td>75</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
Other Code Comparison

The table below presents codes reviewed by the RUC since 2005 with 90 minutes intra-service time. Unlike 157X1, 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>CPT</th>
<th>Long Descriptor</th>
<th>RVW</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>91</th>
<th>33</th>
<th>32</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>55920</td>
<td>Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radionuclide application</td>
<td>8.31</td>
<td>55</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>37184</td>
<td>Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel</td>
<td>8.41</td>
<td>30</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>157X1</td>
<td>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</td>
<td>8.50</td>
<td>58</td>
<td>90</td>
<td>25</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>37241</td>
<td>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)</td>
<td>8.75</td>
<td>22</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>37236</td>
<td>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</td>
<td>8.75</td>
<td>31</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>77778</td>
<td>Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed</td>
<td>8.78</td>
<td>25</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>41019</td>
<td>Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radionuclide application</td>
<td>8.84</td>
<td>55</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>52355</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor</td>
<td>9.00</td>
<td>53</td>
<td>90</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>32994</td>
<td>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</td>
<td>9.03</td>
<td>48</td>
<td>90</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>CPT Code</td>
<td>Description</td>
<td>V code</td>
<td>A code</td>
<td>M code</td>
<td>Status code</td>
<td>CPT Code</td>
<td>Description</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2010</td>
<td>37221</td>
<td>Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>9.75</td>
<td>0.092</td>
<td>0.062</td>
<td>158</td>
<td>38</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>37226</td>
<td>Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>10.24</td>
<td>0.098</td>
<td>0.065</td>
<td>158</td>
<td>38</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>36906</td>
<td>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</td>
<td>10.42</td>
<td>0.104</td>
<td>0.074</td>
<td>141</td>
<td>31</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>37228</td>
<td>Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty</td>
<td>10.75</td>
<td>0.103</td>
<td>0.068</td>
<td>158</td>
<td>38</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>61640</td>
<td>Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel</td>
<td>12.32</td>
<td>0.095</td>
<td>0.053</td>
<td>233</td>
<td>58</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>37244</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intra procedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation</td>
<td>13.75</td>
<td>0.135</td>
<td>0.083</td>
<td>166</td>
<td>31</td>
<td>90</td>
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</tr>
<tr>
<td>2013</td>
<td>93583</td>
<td>Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed</td>
<td>13.75</td>
<td>0.133</td>
<td>0.077</td>
<td>178</td>
<td>48</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>33340</td>
<td>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</td>
<td>14.00</td>
<td>0.136</td>
<td>0.077</td>
<td>183</td>
<td>63</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>33988</td>
<td>Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS</td>
<td>15.00</td>
<td>0.097</td>
<td>0.060</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td></td>
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<tr>
<td>2014</td>
<td>33955</td>
<td>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</td>
<td>16.00</td>
<td>0.108</td>
<td>0.064</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>33956</td>
<td>Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
<td>16.00</td>
<td>0.108</td>
<td>0.064</td>
<td>250</td>
<td>60</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>Rarely</td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>262</td>
<td>90.03 %</td>
<td></td>
</tr>
</tbody>
</table>
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:**

**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
### Anterior Abdominal Hernia Repair

**Current Codes:**
- 49560
- 49654
- 49565
- 49656
- 49570
- 49585
- 49652
- 49590
- 49561
- 49655
- 49566
- 49657
- 49572
- 49587
- 49653
- 49599
- +49568

**New Codes**

<table>
<thead>
<tr>
<th>Size</th>
<th>Initial or Recurrence</th>
<th>Incisional or Ventral Hernia</th>
<th>Repair Initial Incisional or Ventral Hernia; Reducible</th>
<th>Repair Initial Incisional or Ventral Hernia; Incarcerated</th>
<th>Repair Initial Incisional or Ventral Hernia; Recurrent</th>
<th>Repair Initial Incisional or Ventral Hernia; Recurrent, Incarcerated</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3cm</td>
<td>Initial Reduc</td>
<td>43,628</td>
<td>65%</td>
<td>40%</td>
<td>99%</td>
<td>95%</td>
</tr>
<tr>
<td>3-10cm</td>
<td>Initial Reduc</td>
<td>12,662</td>
<td>30%</td>
<td>50%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>&gt;10cm</td>
<td>Initial Reduc</td>
<td>2,191</td>
<td>4%</td>
<td>9%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>&lt;3cm</td>
<td>Initial</td>
<td>23,802</td>
<td>5%</td>
<td>65%</td>
<td>65%</td>
<td>99%</td>
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<tr>
<td>3-10cm</td>
<td>Initial</td>
<td>7,231</td>
<td>5%</td>
<td>30%</td>
<td>30%</td>
<td>1%</td>
</tr>
<tr>
<td>&gt;10cm</td>
<td>Initial</td>
<td>839</td>
<td>4%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>&lt;3cm</td>
<td>Recurrence Reduc</td>
<td>1,642</td>
<td>25%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-10cm</td>
<td>Recurrence Reduc</td>
<td>4,575</td>
<td>65%</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10cm</td>
<td>Recurrence Reduc</td>
<td>622</td>
<td>9%</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3cm</td>
<td>Recurrence</td>
<td>1,090</td>
<td></td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>3-10cm</td>
<td>Recurrence</td>
<td>3,676</td>
<td></td>
<td>70%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>&gt;10cm</td>
<td>Recurrence</td>
<td>473</td>
<td></td>
<td>9%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Initial or Recurrence Reduc</td>
<td>709</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>15%</td>
</tr>
<tr>
<td>Initial or Recurrence</td>
<td>1,035</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**+49X15 Removal of mesh or other prosthetic material**
- 2,831
  - 25% 5%
  - 35% 8%
  - 10% 1%

**157X1 Implantation of absorbable prosthetic material**
- 291

**Utilization Data:**
- **2019 Util:**
  - 22,089
  - 7,253
  - 5,211
  - 1,097
  - 18,847
  - 9,327
  - 714
  - 12,728
  - 4,804
  - 3,748
  - 1,829
  - 4,804
  - 3,748
  - 1,503
  - 495
  - 7,947
  - 5,848

- **Est Util:**
  - 22,089
  - 7,253
  - 5,211
  - 1,097
  - 18,847
  - 9,327
  - 714
  - 12,728
  - 4,804
  - 3,748
  - 1,829
  - 4,804
  - 3,748
  - 1,503
  - 495
  - 7,947
  - 5,848

**Other Codes:**
- Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, abdomen, peritoneum and omentum
- 2019 Util: 27,767
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<td>Other Surgery</td>
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<td>49X14</td>
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<td>Other Surgery</td>
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<td></td>
<td>Other Surgery</td>
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<td>157X1</td>
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<td>Colorectal Surgery</td>
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<tr>
<td></td>
<td>Other Surgery</td>
<td>15</td>
</tr>
</tbody>
</table>
ISSUE: Anterior Abdominal Hernia Repair
TAB: 9
Review

DESC

RVW

SOURCE

Year

CPT

REF1
REF2
Current
Current
Current
Current
Current
Current
Current
SVY
REC

2016
2015
2000
2000
2000
2000
2011
2011
1993
2021

31600
43210
49560
49570
49585
49590
49652
49654
49568
49X01
49X01

Tracheostomy, planned (separate procedure);

Glob Resp IWPUT WPUT

REF1
REF2
Current
Current
Current
Current
Current
Current
Current
SVY
REC

2004
2014
2000
2000
2011
2000
2011
2011
1993
2021

11005
33956
49561
49572
49587
49590
49653
49655
49568
49X02
49X02

Debridement of skin, subcutaneous tissue, muscle and fasc 0

REF1
REF2
Current
Current
Current
Current
Current
Current
Current
SVY
REC

2004
2004
2000
2000
2000
2000
2011
2011
1993
2021

11006
11004
49560
49570
49585
49590
49652
49654
49568
49X03
49X03

Debridement of skin, subcutaneous tissue, muscle and fasc 0

REF1
REF2
Current
Current
Current
Current
Current
Current
Current
SVY
REC

2004
2005
2000
2000
2011
2000
2011
2011
1993
2021

11005
33891
49561
49572
49587
49590
49653
49655
49568
49X04
49X04

Debridement of skin, subcutaneous tissue, muscle and fasc 0

REF1
REF2
Current
Current
Current
Current
Current
Current

2014
2004
2000
2000
2000
2000
2011
2011

21813
11005
49560
49570
49585
49590
49652
49654

Open treatment of rib fracture(s) with internal fixation, inclu

0
0
Repair initial incisional or ventral hernia; reducible
090
Repair epigastric hernia (eg, preperitoneal fat); reducible (s 090
Repair umbilical hernia, age 5 years or older; reducible
090
Repair spigelian hernia
090
Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
0
Initial, Reducible, < 3cm
25th percentile RVW
0
Esophagogastroduodenoscopy, flexible, transoral; with eso

Extracorporeal membrane oxygenation (ECMO)/extracorpo 0

6
6

39

6
6

Repair initial incisional or ventral hernia; incarcerated or stra 090
Repair epigastric hernia (eg, preperitoneal fat); incarcerate 090
Repair umbilical hernia, age 5 years or older; incarcerated 090

090
Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
0
Initial, Incarcerated/Strangulated, < 3cm
0
25th percentile RVW
Repair spigelian hernia

Debridement of skin, subcutaneous tissue, muscle and fasc 0

090
Repair epigastric hernia (eg, preperitoneal fat); reducible (s 090
Repair umbilical hernia, age 5 years or older; reducible
090
Repair spigelian hernia
090
Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
0
Initial, Reducible, 3-10cm
25th percentile RVW
0

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Repair initial incisional or ventral hernia; reducible

Bypass graft, with other than vein, transcervical retropharyn 0

41

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Repair initial incisional or ventral hernia; incarcerated or stra 090
Repair epigastric hernia (eg, preperitoneal fat); incarcerate 090
Repair umbilical hernia, age 5 years or older; incarcerated 090
Repair spigelian hernia

090

Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090
Implantation of mesh or other prosthesis for open incisiona ZZZ

Initial, Incarcerated/Strangulated, 3-10cm
25th percentile RVW

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Debridement of skin, subcutaneous tissue, muscle and fasc 0
Repair initial incisional or ventral hernia; reducible
090
Repair epigastric hernia (eg, preperitoneal fat); reducible (s 090
Repair umbilical hernia, age 5 years or older; reducible
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Repair spigelian hernia
090
Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090

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25th MED 75th

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INTRA
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MIN 25th MED 75th MAX P-SD

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POST Facility
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MIN 25th MED 75th MAX

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Overnight with visit on same date

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Implantation of mesh or other prosthesis for open incisiona ZZZ

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REF1
REF2
Current
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2004
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1993
2021

11005
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49X06
49X06

Debridement of skin, subcutaneous tissue, muscle and fasc 0

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REF1
REF2
Current
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REC

2010
2018
2000
2007
1993
2021

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Revascularization, endovascular, open or percutaneous, fe

REF1
REF2
Current
Current
Current
SVY
REC

2014
2004
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2007
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Open treatment of rib fracture(s) with internal fixation, inclu

REF1
REF2
Current
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Current
SVY
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2004
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2021

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Debridement of skin, subcutaneous tissue, muscle and fasc 0

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49X10
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Bypass graft, with other than vein, transcervical retropharyn 0

REF1
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Current
Current
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2004
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2021

Debridement of skin, subcutaneous tissue, muscle and fasc 0

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49X11
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REF1
REF2
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Current
Current

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2000
2007
1993

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Transcatheter permanent occlusion or embolization (eg, fo

Initial, Reducible, > 10cm
25th percentile RVW

Transcatheter permanent occlusion or embolization (eg, fo

0

Repair initial incisional or ventral hernia; incarcerated or stra 090
Repair epigastric hernia (eg, preperitoneal fat); incarcerate 090
Repair umbilical hernia, age 5 years or older; incarcerated 090
Repair spigelian hernia

090

Laparoscopy, surgical, repair, ventral, umbilical, spigelian o 090
Laparoscopy, surgical, repair, incisional hernia (includes me 090
Implantation of mesh or other prosthesis for open incisiona ZZZ

Initial, Incarcerated/Strangulated, > 10cm
Median RVW

0
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0
Preperitoneal pelvic packing for hemorrhage associated wi 0
Repair recurrent incisional or ventral hernia; reducible
090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
0
Recurrent, Reducible, < 3cm
25th percentile RVW
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Debridement of skin, subcutaneous tissue, muscle and fasc 0
Repair recurrent incisional or ventral hernia; reducible
090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
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Recurrent, Incarcerated/Strangulated, < 3cm
25th percentile RVW
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Debridement of skin, subcutaneous tissue, muscle and fasc 0

090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
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Recurrent, Reducible, 3-10cm
25th percentile RVW
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Repair recurrent incisional or ventral hernia; reducible

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090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
0
Recurrent, Incarcerated/Strangulated, 3-10cm
25th percentile RVW
0
Open treatment of rib fracture(s) with internal fixation, inclu

43

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9

Repair recurrent incisional or ventral hernia; reducible

Debridement of skin, subcutaneous tissue, muscle and fasc 0

090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
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Recurrent, Reducible, > 10cm
XWALK - 37182
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Repair recurrent incisional or ventral hernia; reducible

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Repair recurrent incisional or ventral hernia; reducible
090
Laparoscopy, surgical, repair, recurrent incisional hernia (in 090
Implantation of mesh or other prosthesis for open incisiona ZZZ
Open treatment of rib fracture(s) with internal fixation, inclu

42

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Overnight with visit on same date

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Overnight with visit on same date

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Overnight with visit on same date

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### ISSUE: Anterior Abdominal Hernia Repair

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FACILITY DIRECT PE INPUTS
CPT CODE(S): 49X01-49X15, 157X1
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 |

<table>
<thead>
<tr>
<th>CPT</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>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</td>
</tr>
<tr>
<td>49X02</td>
<td>less than 3 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X03</td>
<td>3 cm to 10 cm, reducible</td>
</tr>
<tr>
<td>49X04</td>
<td>3 cm to 10 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X05</td>
<td>greater than 10 cm, reducible</td>
</tr>
<tr>
<td>49X06</td>
<td>greater than 10 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X07</td>
<td>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</td>
</tr>
<tr>
<td>49X08</td>
<td>less than 3 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X09</td>
<td>3 cm to 10 cm, reducible</td>
</tr>
<tr>
<td>49X10</td>
<td>3 cm to 10 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X11</td>
<td>greater than 10 cm, reducible</td>
</tr>
<tr>
<td>49X12</td>
<td>greater than 10 cm, incarcerated or strangulated</td>
</tr>
<tr>
<td>49X13</td>
<td>Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible</td>
</tr>
<tr>
<td>49X14</td>
<td>incarcerated or strangulated</td>
</tr>
<tr>
<td>157X1</td>
<td>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</td>
</tr>
</tbody>
</table>

No inputs recommended for this facility only ZZZ code:

+49X15 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)):

<table>
<thead>
<tr>
<th>CPT</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X01</td>
<td>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.</td>
</tr>
<tr>
<td>49X02</td>
<td>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.</td>
</tr>
<tr>
<td>49X03</td>
<td>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</td>
</tr>
</tbody>
</table>
FACILITY DIRECT PE INPUTS
CPT CODE(S): 49X01-49X15, 157X1
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)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X04</td>
<td>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. Physical exam reveals a hernia that is tender and nonreducible by manual manipulation. He undergoes hernia repair of a defect that totals more than 10 cm with placement of mesh.</td>
</tr>
<tr>
<td>49X05</td>
<td>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.</td>
</tr>
<tr>
<td>49X06</td>
<td>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.</td>
</tr>
<tr>
<td>49X07</td>
<td>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.</td>
</tr>
<tr>
<td>49X08</td>
<td>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.</td>
</tr>
<tr>
<td>49X09</td>
<td>A 60-year-old obese male presents with 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.</td>
</tr>
<tr>
<td>49X10</td>
<td>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.</td>
</tr>
<tr>
<td>49X11</td>
<td>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.</td>
</tr>
<tr>
<td>49X12</td>
<td>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 ...</td>
</tr>
</tbody>
</table>
FACILITY DIRECT PE INPUTS

CPT CODE(S): 49X01-49X15, 157X1
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)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>49X13</td>
<td>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.</td>
</tr>
<tr>
<td>49X14</td>
<td>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.</td>
</tr>
<tr>
<td>157X1</td>
<td>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.</td>
</tr>
</tbody>
</table>

No inputs recommended for this facility only ZZZ code:

+49X15 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.

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
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:

   **49X01-49X14**
   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.

      | 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 49X01-49X14. These times are consistent with all major surgical procedures and the hernia repair procedures represented by 49X01-49X14 are all major surgery.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Clinical Staff Work</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete pre-service diagnostic and referral forms</td>
<td>Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.</td>
<td>5</td>
</tr>
<tr>
<td>Coordinate pre-surgery services (including test results)</td>
<td>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.</td>
<td>20</td>
</tr>
<tr>
<td>Schedule space and equipment in facility</td>
<td>Staff interacts with facility to schedule space, supplies, equipment, and review checklists.</td>
<td>8</td>
</tr>
<tr>
<td>Provide pre-service education/obtain consent</td>
<td>Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.</td>
<td>20</td>
</tr>
<tr>
<td>Complete pre-procedure phone calls and prescription</td>
<td>Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission questions.</td>
<td>7</td>
</tr>
</tbody>
</table>

157X1
The typical patient undergoing 157X1 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 157X1 is to crosswalk to the times assigned for emergent procedures.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Clinical staff work</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete pre-service diagnostic and referral forms</td>
<td>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.</td>
<td>5</td>
</tr>
<tr>
<td>Coordinate pre-surgery services (including test results)</td>
<td>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.</td>
<td>7</td>
</tr>
<tr>
<td>Schedule space and equipment in facility</td>
<td>Staff interacts with facility to schedule space, supplies, equipment, and review checklists.</td>
<td>4</td>
</tr>
<tr>
<td>Provide pre-service education/obtain consent</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Complete pre-procedure phone calls and prescription</td>
<td>Staff confirms the surgeon's preoperative medication changes and new medication orders are documented in the facility and office medical records.</td>
<td>4</td>
</tr>
</tbody>
</table>
FACILITY DIRECT PE INPUTS

CPT CODE(S): 49X01-49X15, 157X1
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:

49X01 and 49X07

The typical patient for 49X01 and 49X07 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.
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 | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z | AA |
| 2 | 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 | Facility | Facility | Facility | Facility |
| 3 | TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 |
| 4 | TOTAL COST OF CLINICAL STAFF TIME | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 | 128.0 |
| 5 | TOTAL COST OF POST-SERVICE CLINICAL STAFF TIME | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 |
| 6 | TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 | $87 |
| 7 | END TO END | Start: Patient leaves office/facility | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 |

**Notes:**
- **End to End:** Start and end times from the end of the global period.
- **Post-Service Period:** Start: Patient leaves office/facility.
- **Pre-Service Period:** Start: Following visit when decision for surgery/procedure made.
- **Service Period:** Start: When patient enters office/facility for surgery/procedure.
- **Pre-Service Period:** Start: Following visit when decision for surgery/procedure made.
- **Service Period:** Start: When patient enters office/facility for surgery/procedure.

**Specialty:** ACS, SAGES, ASCRS

**Revision Date (if applicable):** 99214 53 minutes, 99212 27 minutes.
<table>
<thead>
<tr>
<th>Location</th>
<th>Activity Code</th>
<th>Clinical Activity Code</th>
<th>Meeting Date: 04/2021</th>
<th>Revision Date (if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td>GLOBAL PERIOD</td>
<td>CA001</td>
<td>Specialty: ACS, SAGES, ASCRS</td>
<td></td>
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<tr>
<td>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</td>
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<td>$ 0.00</td>
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<td>TOTAL PRE-SERVICE CLINICAL STAFF TIME</td>
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<tr>
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<tr>
<td>TOTAL POST-SERVICE CLINICAL STAFF TIME</td>
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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 49X15 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 49X15 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 49X15 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 49X15 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
William Harb, MD, FACS
John S. Roth, MD, FACS

ACS CPT Advisor
ASCRS CPT Advisor
SAGES CPT Advisor

Charles Mabry, MD, FACS
Steven Sentovich, MD, FACS
Ketan Sheth, MD, FACS

ACS RUC Advisor
ASCRS RUC Advisor
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 craniocaudal 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 49X15 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
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

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); incarcerated or strangulated

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

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); incarcerated or strangulated

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, incarcered or strangulated

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); incarcerated or strangulated

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, incarcered or strangulated

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, incarcered or strangulated

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); incarcered or strangulated

Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, includes placement of mesh or other prosthesis, when performed; incarcered or strangulated

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)

(For removal of infected mesh, use 11008)
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 requested 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.
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.
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.

920XX Orthoptic training; under supervision of a physician or other qualified health care professional

The new CPT code 920XX 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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
(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 920XX and 92065.**

**New Technology**

CPT codes 920XX 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲92065</td>
<td>D1</td>
<td>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation, performed by a physician or other qualified health care professional</td>
<td>XXX</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 92065 in conjunction with 920XX, 058XT, 059XT, when performed on the same day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>●920XX</td>
<td>D2</td>
<td>under supervision of a physician or other qualified health care professional</td>
<td>XXX</td>
<td>0.00 (PE Only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Do not report 920XX in conjunction with 92065, 058XT, 059XT, when performed on the same day)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
CPT Code: 92065

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
RUC Recommended RVU: 0.71

Global Period: XXX    Current Work RVU: 0.37

CPT Descriptor: Orthoptic training; performed by a physician or other qualified health care professional (Do not report 92065 in conjunction with 920XX, 058XT, 059XT, 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Charles Fitzpatrick, OD (AOA)</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Academy of Ophthalmology (AAO), American Optometric Association (AOA)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>92065</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>2302</td>
</tr>
<tr>
<td>Resp N:</td>
<td>34</td>
</tr>
</tbody>
</table>

**Description of Sample:** Random sample of US practicing members of AAO and AOA

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>0.07</td>
<td>0.71</td>
<td>0.93</td>
<td>0.98</td>
<td>110.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>3.00</td>
<td>19.25</td>
<td>30.00</td>
<td>45.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 8.50

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
<td></td>
</tr>
<tr>
<td>99238x 0.00 99239x 0.00</td>
<td>99217x 0.00</td>
</tr>
<tr>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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)

**CPT Code:** 92065

**Recommended Physician Work RVU:** 0.71

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>92065</th>
<th><strong>Specialty Recommended Pre-Service Time</strong></th>
<th><strong>Specialty Recommended Pre Time Package</strong></th>
<th><strong>Adjustments/Recommended Pre-Service Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>2.00</td>
<td>0.00</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 4.00

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)

**CPT Code:** 92065
CPT Code: 92065

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00  99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00  99232x 0.00  99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00  99239x 0.00  99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00  12x 0.00  13x 0.00  14x 0.00  15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00  55x 0.00  56x 0.00  57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00  99225x 0.00  99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>XXX</td>
<td>0.93</td>
<td>Other</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>Other</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>Other</td>
<td>10,729,531</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>93015</td>
<td>XXX</td>
<td>0.75</td>
<td>Other</td>
<td>999,644</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>XXX</td>
<td>0.90</td>
<td>Other</td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 92065</th>
<th>Top Key Reference CPT Code: 99202</th>
<th>2nd Key Reference CPT Code: 99212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>15.00</td>
<td>11.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>36.00</td>
<td>20.00</td>
<td>16.00</td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>16%</td>
<td>16%</td>
<td>42%</td>
<td>26%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

Survey Code Compared to Top Key Reference Code

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26%</td>
<td>21%</td>
<td>53%</td>
</tr>
</tbody>
</table>
## CPT Code: 92065

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>11%</td>
<td>26%</td>
<td>63%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>5%</td>
<td>5%</td>
<td>89%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32%</td>
<td>37%</td>
<td>32%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>50%</td>
<td>13%</td>
<td>38%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### 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 920XX, 058XT, 059XT 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, 920XX, 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 Hsiao’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.

Optometrists 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-valuating 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

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%
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

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 %

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 %

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
### ISSUE: Orthoptic Training

**TAB: 10**

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Desc</th>
<th>Year</th>
<th>Review Year</th>
<th>Resp</th>
<th>Work Per Unit Time</th>
<th>RVW</th>
<th>Total Time</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMO</th>
<th>SURVEY EXPERIENCE</th>
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<td>30</td>
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<td>10 22 30 8 0 5 20 24 2000</td>
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<td></td>
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<td>0.018</td>
<td>0.07</td>
<td>47.5</td>
<td>9.5</td>
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<td>18</td>
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<td>36</td>
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Meeting Date: April 2021

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<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>920XX</td>
<td>Orthoptic training; under supervision of a physician or other qualified health care professional</td>
<td>XXX</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>920XX</td>
<td>A 25-year old female is referred for orthoptic training to address convergence insufficiency issues after concussion</td>
</tr>
</tbody>
</table>

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)
New Code: We anticipate findings similar to 92065 whose findings are below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometry</td>
<td>97%</td>
</tr>
<tr>
<td>Non-facility Performance</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 920XX (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](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

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 Latitude 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)

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>123</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>EQ165</td>
<td>Lens set, trial – Trial lenses allow for the increasing/decreasing the difficulties of the activities being performed</td>
<td></td>
</tr>
<tr>
<td>EQ232</td>
<td>Stereo Trainer – Removed</td>
<td></td>
</tr>
<tr>
<td>EQ236</td>
<td>Telebinocular, ophthalmic – Used as part of the visual activities. Time included reflects time room occupied for the procedure.</td>
<td></td>
</tr>
<tr>
<td>EQ049</td>
<td>Anomaloscope, diagnostic – Removed – No longer the typically used.</td>
<td></td>
</tr>
<tr>
<td>ED009</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>EL006</td>
<td>lane, screening (oph) – Removed – No longer typically performed in this room.</td>
<td></td>
</tr>
<tr>
<td>EF030</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>EF043</td>
<td>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.</td>
<td></td>
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</table>

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:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
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</table>

### PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>92065</td>
<td>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.</td>
</tr>
<tr>
<td>92083</td>
<td>92083 would be an alternative if 92065 cannot be utilized.</td>
</tr>
</tbody>
</table>

### 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.
Meeting Date: April 2021

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
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<td>Orthoptic training; performed by a physician or other qualified health care professional</td>
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**Vignette(s) (vignette required even if PE only code(s)):**

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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%)
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 920XX (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
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 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.

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 (e.g., 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 Latitude 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, diagnostic – 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.
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.
<table>
<thead>
<tr>
<th>Clinical Activity Code</th>
<th>Clinical Staff Type Code</th>
<th>Clinical Staff Type</th>
<th>Clinical Staff Type Rate Per Minute</th>
<th>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation</th>
<th>Orthoptic training; performed by a physician or other qualified health care professional (Do not</th>
<th>Orthoptic training, under supervision of a physician or other qualified health care professional</th>
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**PRE-SERVICE PERIOD**

Start: Following visit when decision for surgery/procedure made

- CA001: L038A
- CA002: L038A
- CA003: L038A
- CA004: L038A
- CA005: L038A
- CA006: L038A
- CA007: L038A
- CA008: L038A
- Other activity: please include short clinical description here and type new

End: When patient enters office/facility for surgery/procedure

**SERVICE PERIOD**

Start: When patient enters office/facility for surgery/procedure:

- Pre-Service (of service period)
  - CA009: L038A
  - CA010: L038A
  - CA011: L038A
  - CA012: L038A
  - CA013: L038A
  - CA014: L038A
  - CA015: L038A
  - CA016: L038A
  - CA017: L038A
  - Other activity: please include short clinical description here and type new

- Intra-Service (of service period)
  - CA018: L038A
  - CA019: L038A
  - CA020: L038A
  - CA021: L038A
  - Other activity: please include short clinical description here and type new

- Post-Service (of service period)
  - CA022: L038A
  - CA023: L038A
  - CA024: L038A
  - CA025: L038A
  - CA026: L038A
  - CA027: L038A
  - CA028: L038A
  - CA029: L038A
  - CA030: L038A
  - Other activity: please include short clinical description here and type new

End: Patient leaves office/facility

**POST-SERVICE PERIOD**

Start: Patient leaves office/facility

- Office visits: List Number and Level of Office Visits
  - 99211: 16 minutes
  - 99212: 27 minutes
  - 99213: 36 minutes
  - 99214: 36 minutes
  - 99215: 36 minutes
  - Other activity: please include short clinical description here and type new

End: with last office visit before end of global period
<table>
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<tr>
<th>Clinical Activity Code</th>
<th>CPT Code</th>
<th>Clinical Staff Type</th>
<th>Clinical Staff Rate Per Minute</th>
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**Supply Code**  
- **SG043**: Price: $1, Unit: 1
- **SK057**: Price: $2, Unit: 1
- **LG053**: Price: $3, Unit: 2

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**NEW**  
- **Pro Vision Therapy Starter System Model VTSSP**: 2229.95, 0.00835499, 38, 38
- **Samet Vision Integrator display/software**: 8249, 0.032668308, 38, 38
In February 2021, the CPT Editorial Panel created two new group caregiver behavior management training codes. CPT codes 96X70 and 96X71 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.

96X70 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 96X70. 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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 96X70. The RUC noted that this recommendation is based on a median group size of six.

96X71 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.
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 96X71. 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.

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<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
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<td>Medicine Behavior Management Services</td>
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</tr>
</tbody>
</table>

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.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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 96X70, 96X71 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 96X70, 96X71 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)
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
</table>
| 96X70   | 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 96X70 for services to the patient and the parent[s]/caregiver[s] during the same session)  
(Do not report 96X70 for less than 31 minutes of service) |
|         |          | XXX                                                                                                                                             | 0.43  |
| 96X71   | E2       | each additional 15 minutes (List separately in addition to code for primary service)  
(Use 96X71 in conjunction with 96X70)  
(Do not report 96X70, 96X71 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  |
CPT Code: 96X70

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96X70  Tracking Number: E1  Original Specialty Recommended RVU: 0.50
Presented Recommended RVU: 0.43  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:** 96X70

**Sample Size:** 10906  **Resp N:** 75

**Description of Sample:** Random Sample of Applicable Subsets

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVV:</td>
<td>1.00</td>
<td>2.40</td>
<td>2.60</td>
<td>3.00</td>
<td>75.00</td>
</tr>
</tbody>
</table>

**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**

**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); 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:** 96X70

**Recommended Physician Work RVU:** 0.43

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Speciality Recommended Pre-Service Time</th>
<th>Speciality Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>2.00</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Speciality Recommended Post-Service Time</th>
<th>Speciality Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>3.00</td>
<td>0.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>XXX</td>
<td>2.40</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Family psychotherapy (without the patient present), 50 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>90847</td>
<td>XXX</td>
<td>2.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36455</td>
<td>XXX</td>
<td>2.43</td>
<td>RUC Time</td>
<td>49</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Exchange transfusion, blood; other than newborn

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
<td>10,388,878</td>
</tr>
</tbody>
</table>

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.

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  

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 96X70</th>
<th>Top Key Reference CPT Code: 90846</th>
<th>2nd Key Reference CPT Code: 90847</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>2.00</td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>10.00</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>3.00</td>
<td>10.00</td>
<td>21.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>15.00</td>
<td>65.00</td>
<td>76.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES  
(of those that selected Key Reference codes)  
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>6%</td>
<td>20%</td>
<td>55%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>21%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>27%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Physical effort required | 2% | 45% | 53%

**Psychological Stress**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>41%</td>
<td>53%</td>
</tr>
</tbody>
</table>

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>6%</td>
<td>17%</td>
<td>53%</td>
<td>24%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- The number of possible diagnoses 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>73%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

- Technical skill required
  - 4% | 44% | 52%
- Physical effort required
  - 6% | 32% | 62%

**Psychological Stress**

- 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

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>40%</td>
<td>53%</td>
</tr>
</tbody>
</table>

**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 96X70; 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 96X71; 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 (96X70) which has an XXX global period, and
  - A second dedicated for use with the add-on code (96X71) 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 behavior 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 – 96X70**

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:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Descriptor</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Family psychotherapy (without patient present), 50 minutes</td>
<td>5 x 1.2 = 6</td>
<td>50 x 1.2 = 60</td>
<td>10 x 1.2 = 12</td>
<td>65 x 1.2 = 78</td>
</tr>
<tr>
<td>96167</td>
<td>Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes</td>
<td>5 x 2 = 10</td>
<td>30 x 2 = 60</td>
<td>10 x 2 = 20</td>
<td>45 x 2 = 90</td>
</tr>
<tr>
<td>96X70</td>
<td>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</td>
<td>1.67(6*) = 10</td>
<td>10(6*) = 60</td>
<td>3.33(6*) = 20</td>
<td>15(6*) = 90</td>
</tr>
<tr>
<td>96170</td>
<td>Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes</td>
<td>5 x 2 = 10</td>
<td>30 x 2 = 60</td>
<td>10 x 2 = 20</td>
<td>45 x 2 = 90</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes</td>
<td>5 x 1.2 = 6</td>
<td>50 x 1.2 = 60</td>
<td>21 x 1.2 = 25</td>
<td>76 x 1.2 = 91</td>
</tr>
<tr>
<td>96164</td>
<td>Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes</td>
<td>2(7*) = 24</td>
<td>35 x 1.72 = 60</td>
<td>14 x 1.72 = 24</td>
<td>63 x 1.72 = 108</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
<td>2(5*) = 10</td>
<td>14(5*) = 70</td>
<td>8(5*) = 40</td>
<td>24(5*) = 120</td>
</tr>
</tbody>
</table>

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.

Response to reviewer comments: 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
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 96X70 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 96X70 and 96X71 which describe Caregiver Behavior Management/Modification Training. Upon initial analysis, the survey data revealed a median performance rate of zero for both 96X70 and 96X71.

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 96X70, 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 96X70 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 96X70 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 96X70. 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 96X70 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 96X70. 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.

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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>60 minutes</td>
<td>90 minutes</td>
<td>90 minutes</td>
<td>180 minutes</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>55 minutes</td>
<td>75 Minutes</td>
<td>90 minutes</td>
<td>90 minutes</td>
<td>180 minutes</td>
</tr>
</tbody>
</table>

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 96X70 for a 60 minute service, or one (1) unit of 96X70, and two (2) units of the 96X71 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 96X70 *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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>15</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>19</td>
</tr>
</tbody>
</table>

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 96X70 (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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre</th>
<th>Intra</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>96X70</td>
<td>XXX</td>
<td>2.60</td>
<td>10</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>+96X71</td>
<td>ZZZ</td>
<td>0.73</td>
<td>0</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

---

**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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>Commonly</td>
</tr>
<tr>
<td>Registered Dietitian/Nutrition Professional</td>
<td>Commonly</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>Commonly</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>75000</td>
<td>28.84 %</td>
</tr>
<tr>
<td>Registered Dietitian Nutritionists</td>
<td>165000</td>
<td>63.46 %</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>20000</td>
<td>7.69 %</td>
</tr>
</tbody>
</table>

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 utilization of G0109 would be similar to utilization of the new services while APA and AACAP believe current utilization for 90846 would be similar. Calculating for differences in time between the existing and surveyed codes yeild the estimated utilization in Medicare.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>25000</td>
<td>25.00 %</td>
</tr>
<tr>
<td>Registered Dietitian Nutritionists</td>
<td>55000</td>
<td>55.00 %</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>20000</td>
<td>20.00 %</td>
</tr>
</tbody>
</table>

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:
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
CPT Code: 96X71

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96X71 Tracking Number: E2
Global Period: ZZZ

Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.12**
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 96X70.]

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 96X70.]

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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>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</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Psychological Association, Academy of Nutrition and Dietetics (AND), American Academy of Child and Adolescent Psychiatry (AACAP)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>96X71</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>10906</td>
</tr>
<tr>
<td>Resp N:</td>
<td>75</td>
</tr>
<tr>
<td><strong>Description of Sample:</strong> Random Sample of Applicable Subsets</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>11.50</td>
<td>288.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.25</td>
<td>0.54</td>
<td>0.73</td>
<td>1.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>15.00</td>
<td>15.00</td>
<td>30.00</td>
<td>150.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99236 (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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>96X71</th>
<th>Recommended Physician Work RVU: 0.12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>96X71</th>
<th>Recommended Physician Work RVU: 0.12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specialty Recommended Post-Service Time</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
CPT Code: 96X71

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96171</td>
<td>ZZZ</td>
<td>0.54</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96168</td>
<td>ZZZ</td>
<td>0.55</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

**Most Recent MPC CPT Code 1**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZZ</td>
<td>0.38</td>
<td>RUC Time</td>
<td>310,854</td>
</tr>
</tbody>
</table>

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)

**Most Recent MPC CPT Code 2**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZZ</td>
<td>1.20</td>
<td>RUC Time</td>
<td>19,219</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidurals, 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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 96X71</th>
<th>Top Key Reference CPT Code: 96171</th>
<th>2nd Key Reference CPT Code: 96168</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>3.00</td>
<td>15.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>3.00</td>
<td>15.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>60%</td>
<td>32%</td>
<td>50%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1%</td>
<td>36%</td>
<td>63%</td>
</tr>
</tbody>
</table>
Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>6%</td>
<td>31%</td>
<td>63%</td>
</tr>
<tr>
<td>required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical effort</td>
<td>4%</td>
<td>49%</td>
<td>47%</td>
</tr>
<tr>
<td>required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of</td>
<td>9%</td>
<td>41%</td>
<td>50%</td>
</tr>
<tr>
<td>significant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>complications,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>morbidity and/or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the skill and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>judgment of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>malpractice suit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Code Compared to
2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>4%</td>
<td>24%</td>
<td>50%</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of</td>
<td>5%</td>
<td>32%</td>
<td>63%</td>
</tr>
<tr>
<td>possible diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/or the number of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>management options</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>that must be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>considered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The amount and/or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>complexity of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical records,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic tests,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/or other</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>information that</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>must be reviewed and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical decision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
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<tbody>
<tr>
<td>Technical skill</td>
<td>7%</td>
<td>32%</td>
<td>64%</td>
</tr>
<tr>
<td>required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical effort</td>
<td>1%</td>
<td>52%</td>
<td>47%</td>
</tr>
<tr>
<td>required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of</td>
<td>4%</td>
<td>49%</td>
<td>47%</td>
</tr>
<tr>
<td>significant</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>complications,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>morbidity and/or</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome depends on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the skill and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>judgment of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>malpractice suit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 96X71; 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 96X70, 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 (96X70) and two units of the add-on code (96X71) 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:
  o One dedicated for use with the base code (96X70) which has an XXX global period, and
  o A second dedicated for use with the add-on code (96X71) 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:
  o 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.
  o 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 – 96X71

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 96X71 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 96X71, 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 96X71, 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 96X70 and 96X71 which describe Caregiver Behavior Management/Modification Training. Upon initial analysis, the survey data revealed a median performance rate of zero for 96X71. The median performance rate of zero for 96X71.

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 96X71, 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 96X71. 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 96X71 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 96X71. 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 96X70 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 96X71. 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 (96X70 and all increments of 96X71)? 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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
</table>
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 96X70, *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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>15</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Min.</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>19</td>
</tr>
</tbody>
</table>

**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 96X71 (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.)
   - [x] 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
CPT Code: 96X71

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. 96X70 XXX 2.60 10 60 20
5. +96X71 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, 96X70, 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, 96X70, to be 100,000 base units/year and considering using the same methodology as we did for the national estimates, we doubled that estimate to meet the survey respondent's indication 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

**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
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
## ISSUE: Caregiver Behavior Management Training

### TAB: 11

### Total IMMD

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<td>90846</td>
<td>XXX</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
<td>57</td>
<td>0.041</td>
<td>0.037</td>
<td>2.40</td>
<td>65</td>
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<td>2nd REF</td>
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<td>Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes</td>
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<td>96X70</td>
<td>XXX</td>
<td>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</td>
<td>75</td>
<td>0.021</td>
<td>0.022</td>
<td>1.00</td>
<td>2.40</td>
<td>2.60</td>
<td>3.00</td>
<td>75.00</td>
<td>120</td>
<td>30</td>
<td>1</td>
<td>58</td>
<td>60</td>
<td>90</td>
<td>720</td>
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<td>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)</td>
<td>75</td>
<td>0.021</td>
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<td>96X70</td>
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<td>Per Patient (Entire Group values divided by 6)</td>
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### 96X71

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<tr>
<td>96X71</td>
<td>ZZZ</td>
<td>Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)</td>
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### SVY 96X71

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<tbody>
<tr>
<td>96X71</td>
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<td>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)</td>
<td>75</td>
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### SVY 96X71

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<tbody>
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<td>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)</td>
<td>75</td>
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### REC 96X71

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<tr>
<td>96X71</td>
<td>ZZZ</td>
<td>Per Patient (Entire Group values divided by 6)</td>
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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date:  April 2021

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>96X70</td>
<td>Multiple-family group behavior modification/management training for guardians/caregivers of a patient</td>
<td>XXX</td>
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<tr>
<td></td>
<td>with a mental or physical health diagnosis, administered by physician or other qualified nonphysician</td>
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<td></td>
<td>health care professional (without the patient present), face-to-face with multiple sets of guardians/</td>
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<td></td>
<td>caregivers; initial 60 minutes</td>
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<tr>
<td>96X71</td>
<td>Multiple-family group behavior modification/management training for guardians/caregivers of a patient</td>
<td>ZZZ</td>
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Vignette(s) (vignette required even if PE only code(s)):

<table>
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<tr>
<td>96X70</td>
<td>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 result 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.</td>
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<tr>
<td>96X70</td>
<td>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.</td>
</tr>
<tr>
<td>96X71</td>
<td>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 96X70.]</td>
</tr>
<tr>
<td>96X71</td>
<td>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 96X70.]</td>
</tr>
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</table>

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): 96X70-96X71

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 96X70: 90846 | Family psychotherapy (without the patient present), 50 minutes which was the key reference service selected by 76% of our survey respondents. |
| Reference for 96X71: 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
FACILITY DIRECT PE INPUTS

CPT CODE(S): 96X70-96X71

SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

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.

   N/A

   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?
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): 96X70-96X71
SPECIALTY SOCIETY(IES): American Psychological Association, Academy of Nutrition and Dietetics (AND), & American Academy of Child and Adolescent Psychiatry (AACAP)
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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):** 96X70-96X71  
**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

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<td>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</td>
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**Vignette(s) (vignette required even if PE only code(s)):**

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| 96X71    | 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 96X70.] |
| 96X71    | 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 96X70.] |
NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 96X70-96X71

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 96X70: 90846; Family psychotherapy (without the patient present), 50 minutes which was the key reference service selected by 76% of our survey respondents. |
| Reference for 96X71: 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. |
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
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](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](http://www.ruc.org) 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
21. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitude 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
NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 96X70-96X71

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)

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.
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**REFERENCE CODE**

- CPT Code 96171
- CPT Code 96X71

**RECOMMENDED**

- Family psychotherapy (without the patient present), 30 minutes
- Multiple-family group behavior modification/management training for guardians/caregivers
- Health behavior intervention, family (without the patient present), face-to-face; each additional
- Multiple-family group behavior modification/management training for guardians/caregivers

**REFERENCE CODE**

- CPT Code 90846
- CPT Code 96X70

**RECOMMENDED**

- Multiple-family group behavior modification/management training for guardians/caregivers
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### Equipment

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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.
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. 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. 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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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
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.
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.

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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<th>CPT Code</th>
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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. |
| 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. |

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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. |
| 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. |

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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*
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 purpose 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

Decision Tree for New vs Established Patients
Initial and Subsequent Services

Some categories apply to both new and established patients (e.g., 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 (i.e., 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)**

<table>
<thead>
<tr>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Elements of Medical Decision Making 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.</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td></td>
<td>• 2 or more self-limited or minor problems; or</td>
<td>Category 1: Tests and documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 stable, chronic illness; or</td>
<td>• Any combination of 2 from the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 acute, uncomplicated illness or injury or</td>
<td>o Review of prior external note(s) from each unique source*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 stable acute illness or</td>
<td>o Review of the result(s) of each unique test*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 acute, uncomplicated injury requiring hospital inpatient or observation level of care</td>
<td>o Ordering of each unique test*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Category 2: Assessment requiring an independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| • 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 | • 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 | • 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 | • 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:  
  o Review of prior external note(s) from each unique source*;  
  o Review of the result(s) of each unique test*;  
  o Ordering of each unique test*;  
  o Assessment requiring an independent historian(s)  

**Category 2: Independent interpretation of tests***  
• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);  

**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
<table>
<thead>
<tr>
<th>High</th>
<th>High</th>
</tr>
</thead>
</table>
|   • 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:  
  o Review of prior external note(s) from each unique source*;  
  o Review of the result(s) of each unique test*;  
  o Ordering of each unique test*;  
  o 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 health 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 (e.g., 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.
**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 appropriate history, including interviews with patient, prehospital personnel, family members, and caregivers in person or by phone as needed, and perform a medically appropriate 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
- **CPT Code:** 99281
- **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

#### Sample

- **Sample Size:** 8316
- **Resp N:** 158

**Description of Sample:**
Emergency physicians, pediatricians, and advanced practice nurses.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
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**Immediate Post Service-Time:** 0.00

**Post Operative Visits Total Min**

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<thead>
<tr>
<th></th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical Care time/visit(s):</strong></td>
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<tr>
<td><strong>Other Hospital time/visit(s):</strong></td>
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<td><strong>Discharge Day Mgmt:</strong></td>
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<td><strong>Office time/visit(s):</strong></td>
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<td><strong>Prolonged Services:</strong></td>
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<td><strong>Sub Obs Care:</strong></td>
<td>99224x 0.00, 99225x 0.00, 99226x 0.00</td>
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**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**

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<table>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediate Post Service-Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
### POST-OPERATIVE VISITS

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>XXX</td>
<td>0.18</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>XXX</td>
<td>0.24</td>
<td>RUC Time</td>
<td>532,709</td>
</tr>
</tbody>
</table>

CPT Descriptor: Smoking and tobacco use cessation counseling visit: intermediate, greater than 3 minutes up to 10 minutes

**Most Recent**

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>72074</td>
<td>XXX</td>
<td>0.25</td>
<td>RUC Time</td>
<td>4,505</td>
</tr>
</tbody>
</table>

CPT Descriptor: Radiologic examination, spine thoracic, minimum of 4 views

### Other Reference CPT Code

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

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.**

<table>
<thead>
<tr>
<th>Number of respondents who choose Top Key Reference Code: 102</th>
<th>% of respondents: 64.9 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents who choose 2nd Key Reference Code: 21</td>
<td>% of respondents: 13.3 %</td>
</tr>
</tbody>
</table>

**TIME ESTIMATES (Median)**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Top Key Reference Code</th>
<th>2nd Key Reference Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>10.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>10.00</td>
<td>7.00</td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>5%</td>
<td>5%</td>
<td>72%</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>70%</td>
<td>22%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>77%</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>
Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>74%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>72%</td>
<td>17%</td>
</tr>
</tbody>
</table>

- 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

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>9%</td>
<td>66%</td>
<td>23%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>76%</td>
<td>10%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>71%</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>66%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>9%</td>
<td>57%</td>
<td>33%</td>
</tr>
</tbody>
</table>

- 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

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.

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>RVW</th>
<th>Total</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>INVO</th>
<th>SURVEY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>99281</td>
<td>XXX</td>
<td>Face to face management related to the evaluation and management of</td>
<td>192</td>
<td>0.027</td>
<td>0.026</td>
<td>0.18</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>2nd REF</td>
<td>99282</td>
<td>XXX</td>
<td>Emergency department visit for the evaluation and management of</td>
<td>25</td>
<td>0.053</td>
<td>0.044</td>
<td>0.78</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>CURRENT</td>
<td>99201</td>
<td>XXX</td>
<td>Emergency department visit for the evaluation and management of</td>
<td>0.048</td>
<td>0.032</td>
<td>0.048</td>
<td>0.48</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>SWY</td>
<td>99201</td>
<td>XXX</td>
<td>Emergency department visit for the evaluation and management of</td>
<td>150</td>
<td>0.025</td>
<td>0.025</td>
<td>0.17</td>
<td>6.18</td>
<td>2.25</td>
</tr>
<tr>
<td>REC</td>
<td>99201</td>
<td>XXX</td>
<td>Emergency department visit for the evaluation and management of</td>
<td>0.025</td>
<td>0.025</td>
<td>0.20</td>
<td>0.20</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

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 Pediatrie 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
CPT Code: 99281

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>118635</td>
<td>43.78 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>36818</td>
<td>13.58 %</td>
</tr>
<tr>
<td>Pediatric Medicine</td>
<td>270</td>
<td>0.01 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>29665</td>
<td>43.79 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>9211</td>
<td>13.59 %</td>
</tr>
<tr>
<td>Pediatric Medicine</td>
<td>677</td>
<td>0.01 %</td>
</tr>
</tbody>
</table>

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 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.
CPT Code: 99282

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99282  Tracking Number H2  Original Specialty Recommended RVU: 0.93
Global Period: XXX  Current Work RVU: 0.93  Presented Recommended 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


CPT Code: 99282

Sample Size: 8316  Resp N: 162

Description of Sample: Emergency physicians, pediatricians, and advanced practice nurses.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>20.00</td>
<td>73.00</td>
<td>200.00</td>
<td>2500.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.18</td>
<td>0.80</td>
<td>0.99</td>
<td>1.20</td>
<td>20.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>12.00</td>
<td>18.00</td>
<td>20.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post Operative Visits

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>Recommended Physician Work RVU: 0.93</th>
</tr>
</thead>
<tbody>
<tr>
<td>99282</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre-Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>18.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
**Post-Operative Visits**

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>XXX</td>
<td>0.93</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>93307</td>
<td>XXX</td>
<td>0.92</td>
<td>RUC Time</td>
<td>4,989</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>95819</td>
<td>XXX</td>
<td>1.08</td>
<td>RUC Time</td>
<td>68,372</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 99282</th>
<th>Top Key Reference CPT Code: 99202</th>
<th>2nd Key Reference CPT Code: 99212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>18.00</td>
<td>15.00</td>
<td>11.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>18.00</td>
<td>20.00</td>
<td>16.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>3%</td>
<td>1%</td>
<td>56%</td>
<td>36%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment | Less | Identical | More |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>9%</td>
<td>55%</td>
<td>36%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>6%</td>
<td>66%</td>
<td>28%</td>
</tr>
<tr>
<td>Physical effort</td>
<td>9%</td>
<td>70%</td>
<td>21%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>6%</td>
<td>65%</td>
<td>28%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>6%</td>
<td>53%</td>
<td>40%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnoses and/or the number of management options that must be considered</td>
<td>4%</td>
<td>55%</td>
<td>41%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

### 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.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Emergency Medicine</td>
<td>802139</td>
<td>56.88 %</td>
</tr>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>136627</td>
<td>9.68 %</td>
</tr>
<tr>
<td>Specialty Pediatric Medicine</td>
<td>1409</td>
<td>0.01 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Emergency Medicine</td>
<td>200570</td>
<td>56.89 %</td>
</tr>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>34192</td>
<td>9.69 %</td>
</tr>
<tr>
<td>Specialty Pediatric Medicine</td>
<td>352</td>
<td>0.01 %</td>
</tr>
</tbody>
</table>

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 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.
CPT Code: 99283

Tracking Number: H3

Original Specialty Recommended RVU: 1.60
Presented Recommended 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>American Academy of Pediatrics, American College of Emergency Physicians, American Nurses Association</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>99283</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>8316</td>
</tr>
<tr>
<td><strong>Description of Sample:</strong></td>
<td>Emergency physicians, pediatricians, and advanced practice nurses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th Pctl</th>
<th>Median*</th>
<th>75th Pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td>0.22</td>
<td>1.50</td>
<td>1.75</td>
<td>2.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>20.00</td>
<td>30.00</td>
<td>35.00</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 0.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99283</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Physician Work RVU:</strong> 1.60</td>
<td></td>
</tr>
</tbody>
</table>

| 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

| Immediate Post Service-Time: | 0.00 | 0.00 | 0.00 |
**Modifiers**

- **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**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>XXX</td>
<td>1.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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.

- **Most Recent**
  - **MPC CPT Code 1** 95861  Global XXX  Work RVU 1.54  Time Source RUC Time  Medicare Utilization 44,204
    **CPT Descriptor 1** Needle electromyography; 2 extremities with or without related paraspinal areas

- **Most Recent**
  - **MPC CPT Code 2** 93351  Global XXX  Work RVU 1.75  Time Source RUC Time  Medicare Utilization 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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99283</th>
<th>Top Key Reference CPT Code: 99203</th>
<th>2nd Key Reference CPT Code: 99213</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>25.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>5.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>30.00</td>
<td>35.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>17%</td>
<td>63%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>27%</td>
<td>70%</td>
</tr>
<tr>
<td>Technical Skill/Physical Effort</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>33%</td>
<td>63%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>4%</td>
<td>39%</td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>3%</td>
<td>25%</td>
<td>72%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>3%</td>
<td>37%</td>
<td>50%</td>
<td>9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>9%</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>43%</td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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. 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.

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
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Emergency Medicine</td>
<td>6630121</td>
<td>60.38%</td>
</tr>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>1107764</td>
<td>10.08%</td>
</tr>
<tr>
<td>Specialty Pediatric Medicine</td>
<td>10978</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Emergency Medicine</td>
<td>1657804</td>
<td>60.39%</td>
</tr>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>277215</td>
<td>10.09%</td>
</tr>
<tr>
<td>Specialty Pediatric Medicine</td>
<td>2744</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

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 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.
### CPT Code: 99284

<table>
<thead>
<tr>
<th>Tracking Number</th>
<th>Original Specialty Recommended RVU: 2.74</th>
</tr>
</thead>
<tbody>
<tr>
<td>H4</td>
<td>Presented Recommended RVU: 2.74</td>
</tr>
<tr>
<td>Global Period</td>
<td>RUC Recommended RVU: 2.60</td>
</tr>
<tr>
<td>XXX</td>
<td></td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital 0%, In the ASC 0%, In the office 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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%</td>
</tr>
<tr>
<td>Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 0%</td>
</tr>
</tbody>
</table>

**Description of Pre-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 medically 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 healthcare 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

**Prentser(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  ***Respn N:** 163

**Description of Sample:** Emergency physicians, pediatricians, and advanced practice nurses.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>120.00</td>
<td>325.00</td>
<td>700.00</td>
<td>1000.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>1.00</td>
<td>2.60</td>
<td>2.95</td>
<td>3.50</td>
<td>40.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>6.00</td>
<td>30.00</td>
<td>40.00</td>
<td>50.00</td>
<td>150.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>CPT Code: 99284</th>
<th>Recommended Physician Work RVU: 2.60</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT Code:</strong></td>
<td><strong>Recommended Physician Work RVU:</strong></td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>40.00</td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>SubObs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>40.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>SubObs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Specialty Society Recommended Data**

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

**CPT Code:** 99284

**Recommended Physician Work RVU:** 2.60

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
**CPT Code: 99284**

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>XXX</td>
<td>2.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>95810</td>
<td>XXX</td>
<td>2.50</td>
<td>RUC Time</td>
<td>116,690</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>10030</td>
<td>000</td>
<td>2.75</td>
<td>RUC Time</td>
<td>8,525</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th>Time Estimate</th>
<th>CPT Code: 99284</th>
<th>Top Key Reference CPT Code: 99204</th>
<th>2nd Key Reference CPT Code: 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>40.00</td>
<td>40.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>10.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>40.00</td>
<td>60.00</td>
<td>70.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>1%</td>
<td>16%</td>
<td>36%</td>
<td>45%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>23%</td>
<td>73%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>23%</td>
<td>73%</td>
</tr>
</tbody>
</table>
Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>24%</td>
<td>72%</td>
</tr>
</tbody>
</table>

Psychological Stress | Less | Identical | More |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>2%</td>
<td>16%</td>
<td>82%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Code Compared to 2nd Key Reference Code

Overall intensity/complexity

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>7%</td>
<td>15%</td>
<td>38%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>23%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>27%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>38%</td>
<td>59%</td>
<td></td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>7%</td>
<td>86%</td>
</tr>
</tbody>
</table>

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 asking 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.

**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 %
CPT Code: 99284

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

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.
CPT Code: 99285

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
RUC Recommended RVU: 4.00

Global Period: XXX  Current Work 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**

<table>
<thead>
<tr>
<th>CPT Code: 99285</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>51.00</td>
<td>218.00</td>
<td>500.00</td>
<td>1200.00</td>
</tr>
</tbody>
</table>

| 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 |

<table>
<thead>
<tr>
<th>Post Operative Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit:**
- 99291 (70)
- 99292 (30)
- 99231 (20)
- 99232 (40)
- 99233 (55)
- 99236 (38)
- 99239 (55)
- 99217 (15)
- 99218 (15)
- 99219 (15)
- 99220 (15)
- 99221 (15)
- 99222 (15)
- 99223 (15)
- 99224 (15)
- 99225 (15)
- 99226 (15)
- 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

<table>
<thead>
<tr>
<th>CPT Code: 99285</th>
</tr>
</thead>
</table>

**Recommended Physician Work RVU:** 4.00

| 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

| Immediate Post Service-Time: | 0.00 | 0.00 | 0.00 |
### CPT Code: 99285

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>XXX</td>
<td>3.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>90792</td>
<td>XXX</td>
<td>4.16</td>
<td>RUC Time</td>
<td>586,327</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Psychiatric diagnostic evaluation with medical services

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>92950</td>
<td>000</td>
<td>4.00</td>
<td>RUC Time</td>
<td>68,953</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: CPR

### Other Reference CPT Code

<table>
<thead>
<tr>
<th>CPT Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 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 %

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 99285</th>
<th>Top Key Reference CPT Code: 99205</th>
<th>2nd Key Reference CPT Code: 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>14.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>59.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>15.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Median Total Time</td>
<td>60.00</td>
<td>88.00</td>
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INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
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<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>1%</td>
<td>2%</td>
<td>8%</td>
<td>11%</td>
<td>76%</td>
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Mental Effort and Judgment

- 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

<table>
<thead>
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<th>Mental Effort and Judgment</th>
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<tbody>
<tr>
<td></td>
<td>6%</td>
<td>12%</td>
<td>82%</td>
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Technical Skill/Physical Effort

- Technical skill required
- Physical effort required

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<tr>
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<tr>
<td>Physical effort required</td>
<td>3%</td>
<td>15%</td>
<td>82%</td>
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CPT Code: 99285

Psychological Stress

<table>
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<tr>
<th></th>
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<th>More</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>7%</td>
<td>90%</td>
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- 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

Survey Code Compared to 2nd Key Reference Code

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<th>Somewhat Less</th>
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<th>Somewhat More</th>
<th>Much More</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
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<td>75%</td>
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Mental Effort and Judgment

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<tr>
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<td>25%</td>
<td>75%</td>
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</table>

- 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

Technical Skill/Physical Effort

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<tr>
<th>Technical skill required</th>
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<th>Identical</th>
<th>More</th>
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<td>75%</td>
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</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
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<td>0%</td>
<td>20%</td>
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Psychological Stress

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<td></td>
<td>5%</td>
<td>10%</td>
<td>85%</td>
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</table>

- 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

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 99285 to 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.

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.
### Emergency Department Services

#### SURVEY EXPERIENCE

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<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>RUC</th>
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<th>Year</th>
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<th>Work for the Evaluation</th>
<th>Intra-Time</th>
<th>Time Calculation</th>
<th>Survey Experience</th>
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<td>XXX</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient that may not require an office or other outpatient visit</td>
<td>2019</td>
<td>162</td>
<td>0.000</td>
<td>0.086</td>
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#### Table 12

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#### Table Data

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</table>
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
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 CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.
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.
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.
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.
**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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time on the Date of Encounter Recommendation to CPT</th>
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<tbody>
<tr>
<td>99304</td>
<td>Initial nursing facility care, per day, straightforward or low MDM</td>
</tr>
<tr>
<td>99305</td>
<td>Initial nursing facility care, per day, moderate MDM</td>
</tr>
<tr>
<td>99306</td>
<td>Initial nursing facility care, per day, high MDM</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent nursing facility care, per day, straightforward MDM</td>
</tr>
<tr>
<td>99308</td>
<td>Subsequent nursing facility care, per day, low MDM</td>
</tr>
<tr>
<td>99309</td>
<td>Subsequent nursing facility care, per day, moderate MDM</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent nursing facility care, per day, high MDM</td>
</tr>
</tbody>
</table>

**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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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.
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 (e.g., 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 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
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
| 99304 | 11 | 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 | 12 | 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   | 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   |

| 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. 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   |

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 are professional.
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<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
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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. |

| 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. |
| 99310 | 17 | 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.

| 99315 | 18 | Nursing facility discharge day management; 30 minutes or less | XXX | Tabled until October 2021 RUC Meeting |
| 99316 | 19 | 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)
|        | N/A | XXX
|        |   | (2021 work RVU = 1.71)
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

Decision Tree for New vs Established Patients
Initial and Subsequent Services

Some categories apply to both new and established patients (e.g., 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 (i.e., 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)

<table>
<thead>
<tr>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Elements of Medical Decision Making 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.</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
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<tr>
<td>Low</td>
<td>Low</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
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<td></td>
<td>2 or more self-limited or minor problems; or</td>
<td>Category 1: Tests and documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 stable, chronic illness; or</td>
<td>• Any combination of 2 from the following:</td>
<td></td>
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<tr>
<td></td>
<td>1 acute, uncomplicated illness or injury or</td>
<td>o Review of prior external note(s) from each unique source*;</td>
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<td></td>
<td>1 stable acute illness or</td>
<td>o Review of the result(s) of each unique test*;</td>
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<td></td>
<td>1 acute, uncomplicated illness or injury requiring</td>
<td>o Ordering of each unique test*;</td>
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<td></td>
<td>hospital inpatient or observation level of care</td>
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<td>Category 2: Assessment requiring an independent historian(s)</td>
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<td></td>
<td></td>
<td>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
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<tr>
<td>Category 1: Tests, documents, or independent historian(s)</td>
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<td>----------------------------------------------------------</td>
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<td>- Any combination of 3 from the following:</td>
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<td>- Review of prior external note(s) from each</td>
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<td>unique source*;</td>
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<tr>
<td>- Review of the result(s) of each unique test*;</td>
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<tr>
<td>- Ordering of each unique test*;</td>
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<tr>
<td>- Assessment requiring an independent historian(s)</td>
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<tr>
<td>or</td>
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<td></td>
<td></td>
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<tr>
<td>Category 2: Independent interpretation of tests</td>
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<tr>
<td>- Independent interpretation of a test performed by</td>
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<td>another physician/other qualified health care</td>
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<tr>
<td>professional (not separately reported);</td>
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<td>or</td>
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<tr>
<td>Category 3: Discussion of management or test interpretation</td>
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<td>- Discussion of management or test interpretation with</td>
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<td>external physician/other qualified health care</td>
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<tr>
<td>professional/appropriate source (not separately</td>
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<td>reported)</td>
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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

(Must meet the requirements of at least 1 out of 3 categories)

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
<table>
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<th>High</th>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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</td>
<td>(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: o Review of prior external note(s) from each unique source*; o Review of the result(s) of each unique test*; o Ordering of each unique test*; o 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)</td>
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<tr>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
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</table>

*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 (e.g., 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 (e.g., 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 health 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 (e.g., 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 (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

**Independent historian(s):** An individual (e.g., 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 (e.g., 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 (e.g., 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 (e.g., 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 (i.e., 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 (e.g., 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.
CPT Code: 99304  Tracking Number 11

Original Specialty Recommended RVU: 1.60

Presented 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, pulmonary, abdominal and genitourinary (GU) exams for evidence of obstructive urinary retention and fecal impaction; evaluating patient's ability to communicate; and assessing safety of patient's gait.

Description of Post-Service Work: Follow up with telephone 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 decision maker the preferred intensity of care as it relates to do not resuscitate (DNR) orders for this patient.
### SURVEY DATA

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>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</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAPM&amp;R, ACP, AGS, AMDA, ANA, APMA</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>99304</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>8275</td>
</tr>
<tr>
<td>Resp N:</td>
<td>203</td>
</tr>
</tbody>
</table>

#### Description of Sample:
- Random

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>2.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.50</td>
<td>1.50</td>
<td>1.70</td>
<td>2.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>6.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>20.00</td>
<td>25.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>5.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Post Operative Visits

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>XXX Global Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99304</th>
<th>Recommended Physician Work RVU: 1.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>25.00</td>
<td></td>
</tr>
</tbody>
</table>

#### 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)

<table>
<thead>
<tr>
<th>XXX Global Code</th>
</tr>
</thead>
</table>

| Immediate Post Service-Time: | 5.00 | 0.00 | 5.00 |
### Post-Operative Visits

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
</table>

- **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

### 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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>XXX</td>
<td>1.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>XXX</td>
<td>0.93</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>XXX</td>
<td>1.60</td>
<td>RUC Time</td>
<td>11,452,897</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>78072</td>
<td>XXX</td>
<td>1.60</td>
<td>RUC Time</td>
<td>12,267</td>
</tr>
</tbody>
</table>

CPT Descriptor 2: Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>70492</td>
<td>XXX</td>
<td>1.62</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 99304

CPT Descriptor: Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections

**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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99304</th>
<th>Top Key Reference CPT Code: 99203</th>
<th>2nd Key Reference CPT Code: 99202</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>6.00</td>
<td>5.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>25.00</td>
<td>25.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>5.00</td>
<td>5.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>36.00</td>
<td>35.00</td>
<td>20.00</td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>3%</td>
<td>44%</td>
<td>48%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8%</td>
<td>48%</td>
<td>44%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>3%</td>
<td>71%</td>
<td>26%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>2%</td>
<td>59%</td>
<td>39%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>7%</td>
<td>40%</td>
<td>53%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>52%</td>
<td>39%</td>
<td>9%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>4%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
</tbody>
</table>
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

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.
CPT Code: 99305

Tracking Number: I2

Original Specialty Recommended RVU: 2.50
Presented Recommended RVU: 2.50
RUC Recommended RVU: 2.50

Global Period: XXX

Current Work RVU: 2.35

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 diagnostic 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 |

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>5.00</td>
<td>21.00</td>
<td>82.00</td>
<td>962.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.75</td>
<td>2.50</td>
<td>2.75</td>
<td>3.00</td>
<td>4.75</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>25.00</td>
<td>35.00</td>
<td>45.00</td>
<td>180.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**  
Total Min** | CPT Code and Number of Visits
---|---
Critical Care time/visit(s): | 0.00 | 99291x | 99292x | 0.00 |
Other Hospital time/visit(s): | 0.00 | 99231x | 99232x | 99233x | 0.00 |
Discharge Day Mgmt: | 0.00 | 99238x | 99239x | 99217x | 0.00 |
Office time/visit(s): | 0.00 | 99211x | 12x | 13x | 0.00 | 14x | 15x | 0.00 |
Prolonged Services: | 0.00 | 99354x | 55x | 0.00 | 56x | 0.00 | 57x | 0.00 |
Sub Obs Care: | 0.00 | 99224x | 99225x | 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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99305</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>10.00</td>
<td></td>
<td>10.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>35.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time:</td>
<td>10.00</td>
<td></td>
<td>10.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td></td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td></td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>XXX</td>
<td>2.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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 minutes of total time is spent on the date of the encounter.

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>XXX</td>
<td>1.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

**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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>XXX</td>
<td>2.60</td>
<td>RUC Time</td>
<td>10,714,246</td>
</tr>
</tbody>
</table>

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 minutes of total time is spent on the date of the encounter.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>95810</td>
<td>XXX</td>
<td>2.50</td>
<td>RUC Time</td>
<td>272,131</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Polysomnography; age 6 or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>75574</td>
<td>XXX</td>
<td>2.40</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 99305

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99305</th>
<th>Top Key Reference CPT Code: 99204</th>
<th>2nd Key Reference CPT Code: 99203</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>10.00</td>
<td>10.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>35.00</td>
<td>40.00</td>
<td>25.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>10.00</td>
<td>10.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>55.00</td>
<td>60.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>2%</td>
<td>24%</td>
<td>57%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5%</td>
<td>31%</td>
<td>64%</td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>3%</td>
<td>54%</td>
<td>43%</td>
</tr>
<tr>
<td>physical required</td>
<td>3%</td>
<td>51%</td>
<td>46%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>3%</td>
<td>27%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>4%</td>
<td>36%</td>
<td>44%</td>
<td>16%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgency of decision</td>
<td>4%</td>
<td>48%</td>
<td>48%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill</td>
<td>8%</td>
<td>72%</td>
<td>20%</td>
</tr>
<tr>
<td>physical required</td>
<td>0%</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>8%</td>
<td>36%</td>
<td>56%</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total HMO Discharges</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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 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 10/35/10/55/2.75. 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Work RVUs</td>
<td>Global Period</td>
<td>Ratio of CPT Codes</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>---------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99307</td>
<td>1.5</td>
<td>1.93</td>
<td>1.86</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99308</td>
<td>1.67</td>
<td>1.74</td>
<td>1.48</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99309</td>
<td>1.5</td>
<td>1.49</td>
<td>1.46</td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99304</td>
<td>0.72</td>
<td>0.75</td>
<td>0.81</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99305</td>
<td>0.86</td>
<td>0.85</td>
<td>0.77</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99306</td>
<td>0.9</td>
<td>0.875</td>
<td>0.80</td>
</tr>
<tr>
<td>99315</td>
<td>25</td>
<td>40</td>
<td>1.5</td>
</tr>
<tr>
<td>99316</td>
<td>40</td>
<td>63</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99316 to 99315</td>
<td>1.6</td>
<td>1.575</td>
<td>1.67</td>
</tr>
</tbody>
</table>

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
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 volume 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

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.
CPT Code: 99306

Tracking Number  I3

Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
RUC Recommended RVU: **3.50**

Global Period: XXX  Current Work RVU: **3.06**

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 scale insulin and psychotropic regimen. Discuss patient's multiple, still unstable, health problems with health care providers. Assess current status of cardiopulmonary 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

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>10.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survey RVW:</td>
<td>1.00</td>
<td>3.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-Service Evaluation Time:</td>
<td>15.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intra-Service Time:</td>
<td>9.00</td>
<td>35.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 15.00

**Post Operative Visits Total Min**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99306</th>
<th>Recommended Physician Work RVU: 3.50</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
<td>Specialty Recommended Pre Time Package</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>15.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>50.00</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99306</th>
<th>Immediate Post Service-Time: 15.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Recommended Post-Service Time</td>
<td>Specialty Recommended Post Time Package</td>
</tr>
<tr>
<td></td>
<td>15.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
CPT Code: 99306

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>XXX</td>
<td>3.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99496</td>
<td>XXX</td>
<td>3.79</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>XXX</td>
<td>3.50</td>
<td>RUC Time</td>
<td>2,923,626</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>90962</td>
<td>XXX</td>
<td>3.57</td>
<td>RUC Time</td>
<td>213,048</td>
</tr>
</tbody>
</table>

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 health care professional per month.

Other Reference CPT Code

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>50328</td>
<td>XXX</td>
<td>3.50</td>
</tr>
</tbody>
</table>
CPT Code: 99306

CPT Descriptor: Backbench reconstruction of cadaver or living donor renal allograft prior to transplant; atrial anastomosis, each

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99306</th>
<th>Top Key Reference CPT Code: 99205</th>
<th>2nd Key Reference CPT Code: 99496</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>15.00</td>
<td>14.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>50.00</td>
<td>59.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>15.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>80.00</td>
<td>88.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>2%</td>
<td>12%</td>
<td>36%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>3%</td>
<td>16%</td>
<td>81%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>2%</td>
<td>38%</td>
<td>60%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>2%</td>
<td>44%</td>
<td>54%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>1%</td>
<td>14%</td>
<td>85%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>3%</td>
<td>43%</td>
<td>54%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>0%</td>
<td>17%</td>
<td>33%</td>
<td>47%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>10%</td>
<td>27%</td>
<td>63%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>7%</td>
<td>40%</td>
<td>53%</td>
</tr>
<tr>
<td>Psychological Stress</td>
<td>7%</td>
<td>10%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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 assistants 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 15/50/80/3.75 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 14/59/88/3.5 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 0/75/75/3.79.

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 0/70/70/3.57

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99307</td>
<td>1.5</td>
<td>1.93</td>
<td>1.86</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99308</td>
<td>1.67</td>
<td>1.74</td>
<td>1.48</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99309</td>
<td>1.5</td>
<td>1.49</td>
<td>1.46</td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99304</td>
<td>0.72</td>
<td>0.75</td>
<td>0.81</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99305</td>
<td>0.86</td>
<td>0.85</td>
<td>0.77</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99306</td>
<td>0.9</td>
<td>0.875</td>
<td>0.80</td>
</tr>
<tr>
<td>99315</td>
<td>25</td>
<td>40</td>
<td>1.5</td>
</tr>
<tr>
<td>99316</td>
<td>40</td>
<td>63</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99316 to 99315</td>
<td>1.6</td>
<td>1.575</td>
<td>1.67</td>
</tr>
</tbody>
</table>

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? (i.e. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>745969</td>
<td>42.60 %</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>341464</td>
<td>19.49 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>171608</td>
<td>9.80 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>592136</td>
<td>42.60 %</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>271048</td>
<td>19.49 %</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>136219</td>
<td>9.79 %</td>
</tr>
</tbody>
</table>

Do many physicians perform this service across the United States? Yes
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.
CPT Code: 99307

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99307  Tracking Number  14  Original Specialty Recommended RVU: 0.70
Global Period: XXX  Current Work RVU: 0.76  Presented Recommended RVU: 0.70
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

**CPT Code:** 99307

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Carlo Milan, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAPM&amp;R, ACP, AGS, AMDA, ANA, APMA</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>99307</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>5903</td>
</tr>
<tr>
<td>Resp N:</td>
<td>196</td>
</tr>
</tbody>
</table>

**Description of Sample:** Random

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>49.00</td>
<td>3000.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.18</td>
<td>0.70</td>
<td>0.80</td>
<td>1.30</td>
<td>4.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>10.00</td>
<td>12.00</td>
<td>15.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Operative Visits</td>
<td>Total Min**</td>
<td>CPT Code and Number of Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.00</td>
<td>99291x 0.00</td>
<td>99292x 0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00</td>
<td>99232x 0.00</td>
<td>99233x 0.00</td>
<td></td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99238x 0.00</td>
<td>99239x 0.00</td>
<td>99217x 0.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99211x 0.00</td>
<td>99212x 0.00</td>
<td>99213x 0.00</td>
<td>99214x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00</td>
<td>12x 0.00</td>
<td>13x 0.00</td>
<td>14x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00</td>
<td>55x 0.00</td>
<td>56x 0.00</td>
<td>57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00</td>
<td>99225x 0.00</td>
<td>99226x 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**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)

**Specialty Society Recommended Data**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99307</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>0.70</td>
</tr>
</tbody>
</table>

### Adjustments/Recommended Pre-Service Time

| Pre-Service Evaluation Time: | 1.00 |
| Pre-Service Positioning Time: | 0.00 |
| Pre-Service Scrub, Dress, Wait Time: | 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)

### Adjustments/Recommended Post-Service Time

| Immediate Post Service-Time: | 1.00 |

**Global Code**

**Physician standard total minutes per E/M visit:** 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)
### TOP KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
<td>10,729,531</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>95251</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
<td>248,288</td>
</tr>
</tbody>
</table>

CPT Descriptor: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>62368</td>
<td>XXX</td>
<td>0.67</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 99307

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%

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 99307</th>
<th>Top Key Reference CPT Code: 99212</th>
<th>2nd Key Reference CPT Code: 99213</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>1.00</td>
<td>2.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>12.00</td>
<td>11.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>1.00</td>
<td>3.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>14.00</td>
<td>16.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>1%</td>
<td>7%</td>
<td>61%</td>
<td>27%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13%</td>
<td>58%</td>
<td>29%</td>
</tr>
</tbody>
</table>
## 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 | 5% | 60% | 35%
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

## 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 | 19% | 51% | 30%
- 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

## 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 | 9% | 60% | 31%
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

---

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IQPUT 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 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Global Period</td>
<td>Work RVUs</td>
<td>Pre-Intra-Post Time</td>
</tr>
<tr>
<td>----------</td>
<td>---------------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99307</td>
<td>1.5</td>
<td>1.93</td>
<td>1.86</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99308</td>
<td>1.67</td>
<td>1.74</td>
<td>1.48</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99309</td>
<td>1.5</td>
<td>1.49</td>
<td>1.46</td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>Ratio of 99308 to 99304</td>
<td>0.72</td>
<td>0.75</td>
<td>0.81</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>Ratio of 99309 to 99305</td>
<td>0.86</td>
<td>0.85</td>
<td>0.77</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>Ratio of 99310 to 99306</td>
<td>0.9</td>
<td>0.875</td>
<td>0.80</td>
</tr>
<tr>
<td>99315</td>
<td>25</td>
<td>40</td>
<td>1.5</td>
</tr>
<tr>
<td>99316</td>
<td>40</td>
<td>63</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99316 to 99315</td>
<td>1.6</td>
<td>1.575</td>
<td>1.67</td>
</tr>
</tbody>
</table>

**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)
CPT Code: 99307

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.
CPT Code: 99308

Tracking Number  15

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  
**CPT Code:** 99308

**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

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>20.00</td>
<td>100.00</td>
<td>350.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.50</td>
<td>1.30</td>
<td>1.44</td>
<td>1.85</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>5.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>3.00</td>
<td>15.00</td>
<td>18.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 4.00

**Post Operative Visits**  
<table>
<thead>
<tr>
<th>Critical Care time/visit(s):</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>99291x 0.00</td>
<td>99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00</td>
</tr>
</tbody>
</table>

**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)

| CPT Code: | 99308 | Recommended Physician Work RVU: | 1.30 |

| 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)

| Immediate Post Service-Time: | 4.00 | 0.00 | 4.00 |

**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)
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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>XXX</td>
<td>1.92</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
<td>10,729,531</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>74170</td>
<td>XXX</td>
<td>1.40</td>
<td>RUC Time</td>
<td>107,476</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>74280</td>
<td>XXX</td>
<td>1.26</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 99308

CPT Descriptor: 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.

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99308</th>
<th>Top Key Reference CPT Code: 99213</th>
<th>2nd Key Reference CPT Code: 99214</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>5.00</td>
<td>5.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>18.00</td>
<td>20.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>4.00</td>
<td>5.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>27.00</td>
<td>30.00</td>
<td>47.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>1%</td>
<td>47%</td>
<td>44%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>6%</td>
<td>56%</td>
<td>37%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 99308

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>5%</td>
<td>67%</td>
<td>29%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>4%</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>2%</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>5%</td>
<td>55%</td>
<td>26%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>13%</td>
<td>42%</td>
<td>44%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>16%</td>
<td>58%</td>
<td>26%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>11%</td>
<td>55%</td>
<td>34%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>6%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
</tbody>
</table>
## 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global Period</th>
<th>Work RVUs</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99308 to 99307</td>
<td>1.5</td>
<td>1.93</td>
<td>1.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99309 to 99308</td>
<td>1.67</td>
<td>1.74</td>
<td>1.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99310 to 99309</td>
<td>1.5</td>
<td>1.49</td>
<td>1.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99308 to 99304</td>
<td>0.72</td>
<td>0.75</td>
<td>0.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99309 to 99305</td>
<td>0.86</td>
<td>0.85</td>
<td>0.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99310 to 99306</td>
<td>0.90</td>
<td>0.875</td>
<td>0.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99315</td>
<td>25</td>
<td>40</td>
<td>1.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99316</td>
<td>40</td>
<td>63</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of 99316 to 99315</td>
<td>1.60</td>
<td>1.575</td>
<td>1.67</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

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.
CPT Code: 99309

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99309   Tracking Number: 16

Original Specialty Recommended RVU: 1.92
Presented Recommended RVU: 1.92
RUC Recommended RVU: 1.92

Global Period: XXX   Current Work RVU: 1.55

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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>30.00</td>
<td>100.00</td>
<td>355.00</td>
<td>2000.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.75</td>
<td>1.92</td>
<td>2.09</td>
<td>2.60</td>
<td>6.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>20.00</td>
<td>30.00</td>
<td>35.00</td>
<td>120.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 10.00

<table>
<thead>
<tr>
<th></th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 99232x 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 99239x 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 12x 99213x 14x 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 55x 99355x 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

**CPT Code:** 99309 **Recommended Physician Work RVU:** 1.92

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>7.00</td>
<td>0.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>30.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

**Immediate Post Service-Time:** 10.00

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 99309

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>XXX</td>
<td>1.92</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>XXX</td>
<td>1.92</td>
<td>RUC Time</td>
<td>106,900,291</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>94002</td>
<td>XXX</td>
<td>1.99</td>
<td>RUC Time</td>
<td>3,816</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>95957</td>
<td>XXX</td>
<td>1.98</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99309</th>
<th>Top Key Reference CPT Code: 99214</th>
<th>2nd Key Reference CPT Code: 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>7.00</td>
<td>5.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>30.00</td>
<td>30.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>10.00</td>
<td>10.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>47.00</td>
<td>45.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
<td>54%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Description</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>2%</td>
<td>51%</td>
<td>47%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Psychological Stress

- 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1%</td>
<td>23%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>15%</td>
<td>15%</td>
<td>50%</td>
<td>21%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9%</td>
<td>32%</td>
<td>59%</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Pre</td>
<td>Intra</td>
<td>Post</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99308</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
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<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
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<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
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<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
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<tr>
<td>99310</td>
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<td>70</td>
<td>2.8</td>
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<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
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<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
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<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99309</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
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<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
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<tr>
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<td>50</td>
<td>80</td>
<td>3.5</td>
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<tr>
<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
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<td>99305</td>
<td>35</td>
<td>55</td>
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<td>1.92</td>
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<td>99310</td>
<td>45</td>
<td>70</td>
<td>2.8</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
</tbody>
</table>

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
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

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.
CPT Code: 99310  Tracking Number 17  Original Specialty Recommended RVU: **2.80**

Presented Recommended RVU: **2.80**

RUC Recommended RVU: **2.80**

Global Period: XXX  Current Work RVU: **2.35**

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)**

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure:</th>
<th>In the hospital 0%</th>
<th>In the ASC 0%</th>
<th>In the office 0%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is:</th>
<th>Discharged the same day 0%</th>
<th>Overnight stay-less than 24 hours 0%</th>
<th>Overnight stay-more than 24 hours 0%</th>
</tr>
</thead>
</table>

| 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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>2.00</td>
<td>15.00</td>
<td>50.00</td>
<td>1500.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>1.00</td>
<td>2.80</td>
<td>3.00</td>
<td>3.60</td>
<td>7.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>30.00</td>
<td>45.00</td>
<td>55.00</td>
<td>180.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits Total Min**<sup>**2**</sup>  
**CPT Code and Number of Visits**

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Code</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>99310</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>2.80</td>
</tr>
</tbody>
</table>

**Pre-Service Evaluation Time: 10.00**

**Pre-Service Positioning Time: 0.00**

**Pre-Service Scrub, Dress, Wait Time: 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**

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>15.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Post-Time Package:</td>
<td>0.00</td>
</tr>
<tr>
<td>Adjustments/Recommended Post-Time:</td>
<td>15.00</td>
</tr>
</tbody>
</table>
CPT Code: 99310

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>XXX</td>
<td>4.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>XXX</td>
<td>2.80</td>
<td>RUC Time</td>
<td>10,388,878</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>XXX</td>
<td>2.60</td>
<td>RUC Time</td>
<td>10,714,246</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>75561</td>
<td>XXX</td>
<td>2.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>
CPT Code: 99310

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences.

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99310</th>
<th>Top Key Reference CPT Code: 99215</th>
<th>2nd Key Reference CPT Code: 99291</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>10.00</td>
<td>10.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>45.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>15.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>70.00</td>
<td>70.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>1%</td>
<td>21%</td>
<td>31%</td>
<td>47%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>1%</td>
<td>30%</td>
<td>69%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Category</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>2%</td>
<td>44%</td>
<td>54%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>1%</td>
<td>45%</td>
<td>54%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th>Category</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>2%</td>
<td>22%</td>
<td>76%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Category</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>11%</td>
<td>32%</td>
<td>58%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Category</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>5%</td>
<td>42%</td>
<td>11%</td>
<td>42%</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>N</th>
<th>Elixhauser Mean/Estimate</th>
<th>Std. Error</th>
<th>HCC Mean/Estimate</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2,617,881</td>
<td>8.839</td>
<td>0.006</td>
<td>2.028</td>
<td>0.001</td>
</tr>
<tr>
<td>2012</td>
<td>2,579,944</td>
<td>8.951</td>
<td>0.007</td>
<td>2.067</td>
<td>0.001</td>
</tr>
<tr>
<td>2013</td>
<td>2,585,660</td>
<td>9.102</td>
<td>0.007</td>
<td>2.107</td>
<td>0.001</td>
</tr>
<tr>
<td>2014</td>
<td>2,639,292</td>
<td>9.178</td>
<td>0.006</td>
<td>2.144</td>
<td>0.001</td>
</tr>
<tr>
<td>2015</td>
<td>2,696,494</td>
<td>9.346</td>
<td>0.006</td>
<td>2.205</td>
<td>0.001</td>
</tr>
<tr>
<td>2016</td>
<td>2,687,022</td>
<td>9.341</td>
<td>0.006</td>
<td>2.287</td>
<td>0.001</td>
</tr>
<tr>
<td>2017</td>
<td>2,742,833</td>
<td>9.554</td>
<td>0.006</td>
<td>2.358</td>
<td>0.001</td>
</tr>
<tr>
<td>2018</td>
<td>2,673,328</td>
<td>9.706</td>
<td>0.006</td>
<td>2.402</td>
<td>0.001</td>
</tr>
</tbody>
</table>

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 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Intra-time</th>
<th>Total Time</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>25</td>
<td>36</td>
<td>1.6</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>Ratio of 99305 to 99304</td>
<td>1.4</td>
<td>1.52</td>
<td>1.56</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>55</td>
<td>2.5</td>
</tr>
<tr>
<td>99306</td>
<td>50</td>
<td>80</td>
<td>3.5</td>
</tr>
<tr>
<td>Ratio of 99306 to 99305</td>
<td>1.42</td>
<td>1.45</td>
<td>1.4</td>
</tr>
<tr>
<td>99307</td>
<td>12</td>
<td>14</td>
<td>0.70</td>
</tr>
<tr>
<td>CPT Code</td>
<td>18</td>
<td>27</td>
<td>1.3</td>
</tr>
<tr>
<td>----------</td>
<td>----</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>99308</td>
<td>1.5</td>
<td>1.93</td>
<td>1.86</td>
</tr>
<tr>
<td>99309</td>
<td>1.67</td>
<td>1.74</td>
<td>1.48</td>
</tr>
<tr>
<td>99310</td>
<td>1.5</td>
<td>1.49</td>
<td>1.46</td>
</tr>
<tr>
<td>99304</td>
<td>0.72</td>
<td>0.75</td>
<td>0.81</td>
</tr>
<tr>
<td>99305</td>
<td>0.86</td>
<td>0.85</td>
<td>0.77</td>
</tr>
<tr>
<td>99306</td>
<td>0.9</td>
<td>0.875</td>
<td>0.80</td>
</tr>
<tr>
<td>99315</td>
<td>1.6</td>
<td>1.575</td>
<td>1.67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>30</th>
<th>47</th>
<th>1.92</th>
</tr>
</thead>
<tbody>
<tr>
<td>99308</td>
<td>30</td>
<td>47</td>
<td>1.92</td>
</tr>
<tr>
<td>99309</td>
<td>45</td>
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<td>1.49</td>
<td>1.46</td>
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<td>0.80</td>
</tr>
<tr>
<td>99315</td>
<td>1.6</td>
<td>1.575</td>
<td>1.67</td>
</tr>
</tbody>
</table>

## 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>1075661</td>
<td>50.19 %</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>402837</td>
<td>18.79 %</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>227132</td>
<td>10.60 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>841520</td>
<td>50.18 %</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>315046</td>
<td>18.78 %</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>177727</td>
<td>10.59 %</td>
</tr>
</tbody>
</table>

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 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.
Original Study

Thirty-Year Trends in Nursing Home Composition and Quality Since the Passage of the Omnibus Reconciliation Act

Shekinah A. Fashaw MSPHa,b,* Kali S. Thomas PhDa,b,c Ellen McCreedy PhDa,b, Vincent Mor PhDa,b,c

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c Center of Innovation in Long-Term Services and Supports, US Department of Veterans Affairs Medical Center, Providence, RI

Keywords: Quality Nursing Home Reform Act OBRA 1987 nursing home characteristics

Abstract

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...
to consumer preferences to remain in the community, “age-in-place,” and efforts to rebalance states’ long-term care budgets, 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. 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 vital 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.
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 by both Medicare and Medicaid (+33.3% in 1995 to 97.1% in 2015). 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 36% to 47%. The share of residents with psychiatric diagnoses has increased 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 required 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.

Table 1
Changes Over Time in Facility Characteristics (1985-2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>1985, Mean (CI)</th>
<th>1995, % or Mean (SD)</th>
<th>2005, % or Mean (SD)</th>
<th>2015, % or Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of nursing homes, n</td>
<td>19,068*</td>
<td>16,824</td>
<td>16,091</td>
<td>15,686</td>
</tr>
<tr>
<td>Percentage dual (Medicare + Medicaid) certified</td>
<td>33.1 (28.9, 37.8)</td>
<td>78.6</td>
<td>93.4</td>
<td>97.1</td>
</tr>
<tr>
<td>Percentage member of a chain</td>
<td>51.24</td>
<td>52.43</td>
<td>56.81</td>
<td></td>
</tr>
<tr>
<td>Percentage for-profit</td>
<td>75.0 (70.9, 79.1)</td>
<td>66.4</td>
<td>66.0</td>
<td>69.1</td>
</tr>
<tr>
<td>Percentage with Alzheimer’s Unit</td>
<td>11.2</td>
<td>18.2</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Average number of beds</td>
<td>100.84 (67.93)</td>
<td>104.97 (65.37)</td>
<td>106.13 (61.31)</td>
<td></td>
</tr>
<tr>
<td>Percentage with 3-49 beds</td>
<td>33.7 (26.8, 41.0)</td>
<td>18.8</td>
<td>14.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Percentage with 50-99 beds</td>
<td>32.4 (28.0, 36.8)</td>
<td>36.0</td>
<td>36.3</td>
<td>37.1</td>
</tr>
<tr>
<td>Percentage with 100-199 beds</td>
<td>27.8 (24.2, 31.5)</td>
<td>38.5</td>
<td>42.2</td>
<td>44.0</td>
</tr>
<tr>
<td>Percentage with ≥200 beds</td>
<td>6.1 (5.1, 7.2)</td>
<td>6.8</td>
<td>6.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Average occupancy rate</td>
<td>87.14 (16.41)</td>
<td>84.43 (15.14)</td>
<td>81.19 (15.79)</td>
<td></td>
</tr>
</tbody>
</table>

CI, confidence interval; SD, standard deviation.
*Weighted number of facilities.

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 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%.

Table 2
Changes Over Time in Resident Demographics, Length of Stay, and Admission Source (1985-2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>1985, Mean (CI) (n = 1,489,508*)</th>
<th>2000, Mean (SD) (n = 16,824)</th>
<th>2005, Mean (SD) (n = 16,091)</th>
<th>2015, Mean (SD) (n = 15,686)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage female</td>
<td>71.6 (70.3, 73.0)</td>
<td>72.1 (13.8)</td>
<td>70.9 (14.0)</td>
<td>66.7 (13.04)</td>
</tr>
<tr>
<td>Percentage black</td>
<td>7.0 (6.2, 7.8)</td>
<td>9.9 (17.8)</td>
<td>10.9 (18.5)</td>
<td>11.6 (18.0)</td>
</tr>
<tr>
<td>Percentage Hispanic</td>
<td>2.8 (2.3, 3.2)</td>
<td>2.9 (9.1)</td>
<td>3.4 (9.8)</td>
<td>4.5 (11.3)</td>
</tr>
<tr>
<td>Percentage white</td>
<td>92.2 (91.4, 93.0)</td>
<td>85.6 (21.3)</td>
<td>83.7 (22.6)</td>
<td>79.3 (24.0)</td>
</tr>
<tr>
<td>Average age, y</td>
<td>79.61 (79.21, 80)</td>
<td>80.95 (7.11)</td>
<td>80.15 (7.68)</td>
<td>79.71 (7.34)</td>
</tr>
<tr>
<td>Percentage long stay</td>
<td>69.3 (22.6)</td>
<td>70.6 (19.3)</td>
<td>68.6 (17.0)</td>
<td></td>
</tr>
<tr>
<td>Percentage admitted from the hospital</td>
<td>66.5 (22.9)</td>
<td>72.8 (21.5)</td>
<td>84.7 (17.2)</td>
<td></td>
</tr>
</tbody>
</table>

CI, confidence interval; SD, standard deviation.
*Weighted number of residents.

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.

Fig. 1. Primary payment source using OSCAR/CASPER Data (1992-2015).

Table 3 Changes Over Time in Resident Function, Mental Health, and Medication Use (1985-2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>1985, % (CI)</th>
<th>1995/2000, Mean (SD)</th>
<th>2005, Mean (SD)</th>
<th>2015, Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 1,489,508)*</td>
<td></td>
<td>(n = 16,824)</td>
<td>(n = 16,091)</td>
<td>(n = 15,686)</td>
</tr>
<tr>
<td>Physical and cognitive function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Activities of Daily Living (ADL) Scale score</td>
<td>15.26 (3.47)</td>
<td>15.60 (3.32)</td>
<td>16.87 (2.62)</td>
<td></td>
</tr>
<tr>
<td>Percentage of residents bed bound</td>
<td>6.5 (5.8, 7.2)</td>
<td>6.6 (9.9)</td>
<td>4.3 (7.4)</td>
<td>3.7 (6.9)</td>
</tr>
<tr>
<td>Percentage of residents chair bound</td>
<td>39.5 (38.1, 40.9)</td>
<td>48.1 (21.3)</td>
<td>55.1 (21.2)</td>
<td>64.3 (21.4)</td>
</tr>
<tr>
<td>Percentage of residents needing assistance with early-loss ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>74.2 (72.8, 75.5)</td>
<td>86.6 (12.4)</td>
<td>88.2 (11.7)</td>
<td>91.8 (10.9)</td>
</tr>
<tr>
<td>Bathing</td>
<td>89.2 (88.1, 90.2)</td>
<td>94.2 (10.1)</td>
<td>95.4 (9.2)</td>
<td>96.5 (8.5)</td>
</tr>
<tr>
<td>Percentage of residents needing assistance with middle-loss ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td>60.2 (58.8, 61.7)</td>
<td>72.7 (16.5)</td>
<td>77.3 (15.4)</td>
<td>85.5 (14.7)</td>
</tr>
<tr>
<td>Toileting</td>
<td>49.2 (47.7, 50.6)</td>
<td>76.6 (15.0)</td>
<td>81.5 (13.9)</td>
<td>88.1 (13.0)</td>
</tr>
<tr>
<td>Percentage of residents needing assistance with late-loss ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>37.7 (36.3, 39.1)</td>
<td>53.0 (22.2)</td>
<td>49.4 (21.9)</td>
<td>56.5 (28.9)</td>
</tr>
<tr>
<td>Percentage of residents with dementia</td>
<td>43.3 (41.9, 44.8)</td>
<td>39.0 (20.0)</td>
<td>45.2 (19.4)</td>
<td>45.3 (18.4)</td>
</tr>
<tr>
<td>Mental health and medication use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of residents with psychiatric diagnosis</td>
<td>11.2 (13.9)</td>
<td>19.8 (17.2)</td>
<td>31.4 (19.5)</td>
<td></td>
</tr>
<tr>
<td>Percentage of residents with schizophrenia</td>
<td>5.7 (5.0, 6.4)</td>
<td>6.1 (9.9)</td>
<td>7.7 (11.0)</td>
<td>10.4 (13.0)</td>
</tr>
<tr>
<td>Percentage of residents receiving antianxiety medications</td>
<td>14.6 (10.2)</td>
<td>17.6 (10.3)</td>
<td>23.0 (11.6)</td>
<td></td>
</tr>
<tr>
<td>Percentage of residents receiving antidepressant medications</td>
<td>19.5 (10.9)</td>
<td>45.8 (14.3)</td>
<td>48.7 (14.5)</td>
<td></td>
</tr>
<tr>
<td>Percentage of residents receiving antipsychotic medication</td>
<td>16.0 (13.1)</td>
<td>26.0 (14.7)</td>
<td>20.1 (14.5)</td>
<td></td>
</tr>
</tbody>
</table>

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.

*Weighted number of residents.

These data are from the 2000, 2005, and 2015 LTCfocUs instead of the OSCAR/CASPER data.

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.\(^{15,17}\) 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.\(^{5}\) 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,\(^{24,25}\) 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.\(^{2,25}\) 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.

<table>
<thead>
<tr>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>Structure (staffing)</td>
</tr>
<tr>
<td>CNA hours per resident day</td>
</tr>
<tr>
<td>LPN hours per resident day</td>
</tr>
<tr>
<td>RN hours per resident day</td>
</tr>
<tr>
<td>Direct care hours per resident day</td>
</tr>
<tr>
<td>Process</td>
</tr>
<tr>
<td>Percentage of residents restrained</td>
</tr>
<tr>
<td>Percentage of residents receiving tube feeding</td>
</tr>
<tr>
<td>Percentage of residents with a catheter</td>
</tr>
<tr>
<td>Percentage of residents receiving inappropriate antipsychotic medication*</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>Percentage of facilities cited for medication errors &gt;5%</td>
</tr>
<tr>
<td>Percentage of residents with pressure ulcers</td>
</tr>
<tr>
<td>Percentage of residents with bowel incontinence</td>
</tr>
<tr>
<td>Percentage of residents with bladder incontinence</td>
</tr>
</tbody>
</table>

CNA, certified nursing aide; LPN, licensed professional nurse; RN, registered nurse; SD, standard deviation.

*These data are from the 2000, 2005, and 2015 LTCFocusUs instead of the OSCAR/CASPER Data.

measures. 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. Prior research indicates that physical restraints are associated with worse outcomes for residents, such as increased depression, less social engagement among NH residents, reduced muscle strength, and pressure ulcers. 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 and death. In 2005, the FDA released a Black Box warning to decrease the use of antipsychotics among older adults. 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. 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. 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.

Despite the success of several prompted voiding interventions, 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. 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, disproportional 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. 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.

References

Hospital Transfer Rates Among US Nursing Home Residents With Advanced Illness Before and After Initiatives to Reduce Hospitalizations

Ellen P. McCarthy, PhD, MPH; Jessica A. Ogarek, MS; Lacey Loomer, MSPH; Pedro L. Gozalo, MSc, PhD; Vincent Mor, PhD; Mary Beth Hamel, MD, MPH; Susan L. Mitchell, MD, MPH

**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.
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. 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 for whom the burdens of hospitalization often outweigh the benefits. 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. 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. 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. 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. Evaluation of the initiative’s first phase in 7 states demonstrated 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. Alternative payment models, such as accountable care organizations and bundled payments, also create financial incentives for nursing homes to reduce hospital transfers. The Hospital Readmissions Reduction Program (HRRP) implemented financial penalties for hospitals with excess readmissions for target conditions including pneumonia, CHF, and COPD. These concurrent initiatives raised national awareness and forged collaborations around transitional care to avoid unnecessary hospitalizations. 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.

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.

Methods
Advanced Illness Cohorts
In this cross-sectional study, the MDS version 3.0 assessments 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. Key differences between MDS 3.0 and MDS 2.0 precluded us from using MDS before 2011. 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 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, 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...
Hospital Transfer Rates Among US Nursing Home Residents With Advanced Illness

Covariates
Age, sex, nonwhite race, dual-eligible status indicating beneficiaries qualifying for both Medicare and Medicaid, MDS 3.0 mortality risk score (MRS3), 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,29 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 File29 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
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 (2.7) vs 3.9 (1.7); 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. Septicemia 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 1. Characteristics of Nursing Home Residents With Advanced Illness by Cohort Year**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Advanced Dementia</th>
<th>Advanced Chronic Obstructive Pulmonary Disease</th>
<th>Advanced Congestive Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents, No.</td>
<td>18 178b</td>
<td>44 385</td>
<td>50 725</td>
</tr>
<tr>
<td>Follow-up, mean (SD), d</td>
<td>232.5 (146.0)</td>
<td>238.2 (143.6)</td>
<td>242.8 (143.0)</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>85.0 (7.6)</td>
<td>85.4 (7.6)</td>
<td>85.6 (7.8)</td>
</tr>
<tr>
<td>Female, No. (%)</td>
<td>12 400 (68.2)</td>
<td>30 760 (69.3)</td>
<td>35 630 (70.2)</td>
</tr>
<tr>
<td>Nonwhite race, No. (%)</td>
<td>1417 (16.0)</td>
<td>2429 (14.6)</td>
<td>2544 (14.3)</td>
</tr>
<tr>
<td>Dual eligible, No. (%)f</td>
<td>12 654 (69.6)</td>
<td>32 238 (72.6)</td>
<td>37 522 (74.0)</td>
</tr>
<tr>
<td>MRS3, mean (SD)d</td>
<td>8.4 (3.6)</td>
<td>8.1 (3.6)</td>
<td>7.9 (3.5)</td>
</tr>
</tbody>
</table>

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.
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 the 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 dementia had multiple hospital transfers during the year, and 63% of the residents had at least one hospital transfer. These findings highlight the need for continued efforts to reduce hospital transfers, particularly for potentially avoidable conditions.
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, 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. 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.

Palliative care and hospice improve the quality of end-of-life care among nursing home residents, including reducing hospitalization rates. 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. 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. 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. 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), 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.

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. 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. Consistent with other studies, we...
observed a leveling off of hospital transfer rates during 2014 to 2016. Chhabra and colleagues\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{46} In addition, nursing homes included in accountable care organizations or other preferred referral
were similar for all-cause and potentially avoidable transfers. Declines in all-cause mortality risk score. In addition, rates of decline were unfounded in this population. CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

Table 3. Mortality and Hospice Enrollment Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Yeara

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Cohort Year*</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced Dementia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-mo Mortality adjusted</td>
<td>% (95% CI)a</td>
<td>52.8 (51.6-53.1)</td>
<td>51.8 (51.3-52.3)</td>
<td>50.5 (50.1-51.0)</td>
<td>52.0 (51.6-52.5)</td>
<td>51.0 (50.5-51.4)</td>
<td>53.3 (52.8-53.7)</td>
</tr>
<tr>
<td>HR (95% CI)b</td>
<td>1 [Reference]</td>
<td>0.97 (0.95-1.00)</td>
<td>0.94 (0.92-0.96)</td>
<td>0.98 (0.95-1.00)</td>
<td>0.95 (0.93-0.98)</td>
<td>1.02 (0.99-1.04)</td>
<td></td>
</tr>
<tr>
<td>Hospice in 12 mo adjusted</td>
<td>% (95% CI)c</td>
<td>27.2 (26.5-27.8)</td>
<td>26.9 (26.5-27.4)</td>
<td>27.1 (26.7-27.4)</td>
<td>27.2 (26.9-27.6)</td>
<td>27.9 (27.6-28.3)</td>
<td>30.0 (29.6-30.4)</td>
</tr>
<tr>
<td>HR (95% CI)d</td>
<td>1 [Reference]</td>
<td>0.97 (0.94-1.01)</td>
<td>0.97 (0.94-1.00)</td>
<td>0.98 (0.95-1.02)</td>
<td>1.01 (0.98-1.04)</td>
<td>1.11 (1.08-1.15)</td>
<td></td>
</tr>
<tr>
<td><strong>Advanced CHF</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>12-mo Mortality adjusted</td>
<td>% (95% CI)a</td>
<td>61.6 (60.6-62.6)</td>
<td>58.9 (58.1-59.6)</td>
<td>55.4 (54.7-56.2)</td>
<td>56.8 (56.0-57.5)</td>
<td>56.3 (55.5-57.0)</td>
<td>57.3 (56.6-58.0)</td>
</tr>
<tr>
<td>HR (95% CI)b</td>
<td>1 [Reference]</td>
<td>0.94 (0.90-0.99)</td>
<td>0.87 (0.83-0.91)</td>
<td>0.87 (0.84-0.90)</td>
<td>0.87 (0.84-0.90)</td>
<td>0.89 (0.86-0.92)</td>
<td></td>
</tr>
<tr>
<td>Hospice in 12 mo adjusted</td>
<td>% (95% CI)c</td>
<td>27.9 (27.0-28.9)</td>
<td>27.1 (26.4-27.8)</td>
<td>25.8 (25.2-26.5)</td>
<td>26.9 (26.2-27.5)</td>
<td>27.4 (26.7-28.0)</td>
<td>29.9 (29.2-30.5)</td>
</tr>
<tr>
<td>HR (95% CI)d</td>
<td>1 [Reference]</td>
<td>0.94 (0.89-0.99)</td>
<td>0.87 (0.83-0.91)</td>
<td>0.91 (0.87-0.95)</td>
<td>0.93 (0.89-0.98)</td>
<td>1.03 (0.98-1.08)</td>
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<tr>
<td><strong>Advanced COPD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-mo Mortality adjusted</td>
<td>% (95% CI)a</td>
<td>57.8 (56.7-58.9)</td>
<td>53.6 (52.8-54.3)</td>
<td>49.9 (49.0-50.5)</td>
<td>51.3 (50.6-52.1)</td>
<td>50.7 (50.0-51.5)</td>
<td>52.2 (51.4-52.9)</td>
</tr>
<tr>
<td>HR (95% CI)b</td>
<td>1 [Reference]</td>
<td>0.88 (0.85-0.91)</td>
<td>0.80 (0.77-0.82)</td>
<td>0.82 (0.79-0.85)</td>
<td>0.82 (0.79-0.85)</td>
<td>0.85 (0.82-0.88)</td>
<td></td>
</tr>
<tr>
<td>Hospice in 12 mo adjusted</td>
<td>% (95% CI)c</td>
<td>24.7 (23.8-25.6)</td>
<td>23.9 (23.2-24.6)</td>
<td>23.1 (22.5-24.0)</td>
<td>23.3 (22.7-24.0)</td>
<td>24.1 (23.4-24.7)</td>
<td>26.2 (25.6-26.9)</td>
</tr>
<tr>
<td>HR (95% CI)d</td>
<td>1 [Reference]</td>
<td>0.92 (0.87-0.97)</td>
<td>0.87 (0.82-0.91)</td>
<td>0.87 (0.83-0.92)</td>
<td>0.91 (0.86-0.95)</td>
<td>1.00 (0.95-1.05)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

* 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).

** 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 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 penalties18 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).
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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Concept and design: All authors.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: McCarthy, Mitchell.
Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: McCarthy, Ogarek, Gozalo, Mor, Hamel, Mitchell.
Obtained funding: Mor, Mitchell.
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Supervision: McCarthy, Gozalo, Mor, Mitchell.
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REFERENCES

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 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 settings 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. 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.

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; 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 SNFists 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>
<thead>
<tr>
<th>Billing Category</th>
<th>2007</th>
<th>2010</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians, No.</td>
<td>435 943</td>
<td>419 299</td>
<td>459 895</td>
</tr>
<tr>
<td>Ever billing in an SNF,(^a) No. (%)</td>
<td>59 724 (13.7)</td>
<td>50 814 (12.1)</td>
<td>45 070 (9.8)</td>
</tr>
<tr>
<td>Billing ≥90% in an SNF,(^b) No. (%)</td>
<td>1496 (0.34)</td>
<td>1697 (0.40)</td>
<td>2225 (0.49)</td>
</tr>
<tr>
<td>Nurse practitioners or physician assistants, No.</td>
<td>64 393</td>
<td>80 029</td>
<td>131 986</td>
</tr>
<tr>
<td>Ever billing in an SNF,(^c) No. (%)</td>
<td>7528 (11.7)</td>
<td>8309 (10.4)</td>
<td>12 470 (9.5)</td>
</tr>
<tr>
<td>Billing ≥90% in an SNF,(^d) No. (%)</td>
<td>1678 (2.6)</td>
<td>2031 (2.5)</td>
<td>3074 (2.3)</td>
</tr>
<tr>
<td>Evaluation and management code bills at SNF, No.</td>
<td>4 731 367</td>
<td>4 538 967</td>
<td>5 205 865</td>
</tr>
<tr>
<td>By physician billing ≥90% in an SNF,(^e) No. (%)</td>
<td>550 425 (11.6)</td>
<td>584 952 (12.9)</td>
<td>747 106 (14.3)</td>
</tr>
<tr>
<td>By nurse practitioner or physician assistant billing ≥90% in an SNF,(^f) No. (%)</td>
<td>49 145 (10.4)</td>
<td>58 235 (12.8)</td>
<td>895 830 (17.2)</td>
</tr>
</tbody>
</table>

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 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.
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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Author Contributions: Drs Teno and Gozalo had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Teno, Gozalo, Trivedi, Mitchell, Bunker, Mor.
Acquisition, analysis, or interpretation of data: Teno, Gozalo, Bunker, Mor.
Drafting of the manuscript: Teno, Bunker.
Critical revision of the manuscript for important intellectual content: Teno, Gozalo, Trivedi, Mitchell, Mor.
Statistical analysis: Teno, Gozalo.
Obtained funding: Teno, Mor.
Administrative, technical, or material support: Teno, Gozalo, Bunker, Mor.
Supervision: Teno, Gozalo, Mor.

Conflict of Interest Disclosures: Dr Trivedi reports consulting fees to edit the Merck Manual. Dr Mor chairs the Independent Quality Committee for HCR ManorCare, Inc. a nursing home chain, for which he receives compensation, and also serves as chair of a Scientific Advisory Committee for navHealth, a postacute care service organization, for which he also receives compensation. No other disclosures are reported.

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Role of the Funder/Sponsor: The National Institute on Aging had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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 file5 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 patient 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).

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.

Rachel M. Werner, MD, PhD
R. Tamara Konetzka, PhD
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).

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.

Regarding the staging of hidradenitis, ultrasonography has also demonstrated that clinical evaluation and commonly used clinical scoring systems can misclassify as healthy skin corporal segments with fluid collections or fistulous tracts underneath. 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. 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. This imaging information may allow better selection of the type of medical treatment or the location and extent of the surgical incision.

Ximena Wortsman, MD

Author Affiliation: Institute for Diagnostic Imaging and Research of the Skin and Soft Tissues, University of Chile, Santiago, Chile.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. The author reported receiving grants from the National Institute on Aging and the National Institute of Arthritis and Musculoskeletal and Skin Diseases, National Institutes of Health, and the National Science Foundation for the creation of the research dataset.

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 PAC2 (https://impactcollaboratory.org/). Although some studies have assessed inpatient rehabilitation facilities patients’ success in
community discharge,\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{8} This definition has a sensitivity (0.85) and specificity (0.89).\textsuperscript{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. 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

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<tr>
<td>Successful discharge SNF to community</td>
<td>2.0 (1.8,2.2)</td>
<td>43.5%</td>
<td>44.1%</td>
<td>45.7%</td>
<td>46.5%</td>
<td>47.4%</td>
<td>48.3%</td>
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<td>50.1%</td>
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<td>Long-stay</td>
<td>−3.6 (−4.4,−2.8)</td>
<td>15.0%</td>
<td>14.2%</td>
<td>13.4%</td>
<td>12.5%</td>
<td>12.2%</td>
<td>11.8%</td>
<td>11.7%</td>
<td>11.3%</td>
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<tr>
<td>Death in SNF</td>
<td>−0.7 (−1.1,−0.3)</td>
<td>16.9%</td>
<td>17.0%</td>
<td>16.2%</td>
<td>16.3%</td>
<td>16.1%</td>
<td>16.4%</td>
<td>16.2%</td>
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<tr>
<td>Death within 90 days of discharge from SNF</td>
<td>−0.2 (−1.0,0.7)</td>
<td>8.9%</td>
<td>8.3%</td>
<td>8.2%</td>
<td>8.4%</td>
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<tr>
<td>Re-entered hospital within 30 days</td>
<td>−2.8 (−3.6,−2.0)</td>
<td>16.0%</td>
<td>16.4%</td>
<td>16.1%</td>
<td>15.8%</td>
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<td>Re-entered hospital within 90 days</td>
<td>−1.7 (−2.3,−1.2)</td>
<td>27.4%</td>
<td>27.8%</td>
<td>27.4%</td>
<td>27.3%</td>
<td>26.6%</td>
<td>25.9%</td>
<td>24.8%</td>
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<tr>
<td>Patient was transferred from SNF to another facility within 30 days</td>
<td>−2.0 (−3.3,−0.7)</td>
<td>5.0%</td>
<td>4.7%</td>
<td>4.5%</td>
<td>4.2%</td>
<td>4.2%</td>
<td>4.1%</td>
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<td>4.3%</td>
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<td>Without Alzheimer’s disease and other related dementias</td>
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<tr>
<td>Successful discharge SNF to community</td>
<td>1.0 (0.8,1.2)</td>
<td>59.0%</td>
<td>58.6%</td>
<td>59.5%</td>
<td>60.1%</td>
<td>61.1%</td>
<td>61.8%</td>
<td>62.5%</td>
<td>62.7%</td>
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<tr>
<td>Long-stay</td>
<td>−3.4 (−4.3,−2.6)</td>
<td>5.5%</td>
<td>5.3%</td>
<td>5.0%</td>
<td>4.8%</td>
<td>4.6%</td>
<td>4.4%</td>
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<tr>
<td>Death in SNF</td>
<td>−1.4 (−1.8,−0.9)</td>
<td>13.9%</td>
<td>14.0%</td>
<td>13.5%</td>
<td>13.2%</td>
<td>12.9%</td>
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<tr>
<td>Death within 90 days of discharge from SNF</td>
<td>−1.1 (−1.5,−0.6)</td>
<td>6.3%</td>
<td>6.2%</td>
<td>6.1%</td>
<td>6.0%</td>
<td>5.9%</td>
<td>5.9%</td>
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<tr>
<td>Re-entered hospital within 30 days</td>
<td>−2.9 (−3.6,−2.1)</td>
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<td>16.8%</td>
<td>16.4%</td>
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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, 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 (ADR D−No ADR D) = 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 (ADR D−No ADR D) = 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 (ADR D−No ADR D) = 0.9 (1.7, 0.1), P < .01).
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

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<td>Successful discharge SNF to community</td>
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<td>44.0%</td>
<td>45.6%</td>
<td>46.1%</td>
<td>47.4%</td>
<td>47.6%</td>
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<td>Long-stay</td>
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<td>14.3%</td>
<td>13.5%</td>
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<td>Death in SNF</td>
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<td>14.8%</td>
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<td>Death within 90 days of discharge from SNF</td>
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<td>Re-entered hospital within 30 days</td>
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<td>Re-entered Hospital within 90 days</td>
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<td>23.8%</td>
<td>25.0%</td>
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<td>22.8%</td>
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<td>Patient was transferred from SNF to another facility within 30 days</td>
<td>-2.0 (-3.7, -0.3)</td>
<td>6.8%</td>
<td>6.1%</td>
<td>5.9%</td>
<td>5.5%</td>
<td>5.4%</td>
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| **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.
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

proportion of beneficiaries discharged and rehospitalized within 30 days and 90 days decreased among both those with (AAPP = −2.8 (−3.6, −2.0) and AAPC = −1.7 (−2.3, −1.2)) and without ADRD (AAPC = −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 (ADRDP−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.
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.

ACKNOWLEDGMENTS

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.

Sponsor’s Role: This research was supported, in part, by NIH P01AG027296.

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**Tab 13 NF RUC Summary**
### Tab 13 NF RUC Summary

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**Note:** The table above lists various services provided, their corresponding CPT codes, and the work and RVW values associated with each. The table also includes the work units per time and the total time for different categories such as Pre-Time and Intra-Time.
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<td>10/1/2010</td>
<td>185</td>
<td>0.071</td>
<td>0.053</td>
<td>1.50</td>
<td>2.10</td>
<td>2.78</td>
<td>8.00</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>SVY</td>
<td>99315</td>
<td>XXX</td>
<td>Nursing facility discharge day management; 30 minutes or less</td>
<td></td>
<td>101</td>
<td>0.080</td>
<td>0.060</td>
<td>1.80</td>
<td>2.50</td>
<td>2.80</td>
<td>8.00</td>
<td>42</td>
<td>10</td>
</tr>
<tr>
<td>IM &amp; FM</td>
<td>99315</td>
<td>XXX</td>
<td>NF Discharge Mgt 30 min or less</td>
<td></td>
<td>69</td>
<td>0.071</td>
<td>0.057</td>
<td>1.50</td>
<td>2.00</td>
<td>2.78</td>
<td>3.80</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>NP &amp; PA</td>
<td>99315</td>
<td>XXX</td>
<td>NF Discharge Mgt 30 min or less</td>
<td></td>
<td>3</td>
<td>0.158</td>
<td>0.077</td>
<td>3.00</td>
<td>1.92</td>
<td>2.27</td>
<td>2.61</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Other, Ped and</td>
<td>99315</td>
<td>XXX</td>
<td>NF Discharge Mgt 30 min or less</td>
<td></td>
<td>1</td>
<td>0.053</td>
<td>0.050</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
<td>30</td>
<td>3</td>
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<tr>
<td>PM&amp;R</td>
<td>99315</td>
<td>XXX</td>
<td>NF Discharge Mgt 30 min or less</td>
<td></td>
<td>11</td>
<td>0.078</td>
<td>0.050</td>
<td>1.00</td>
<td>1.53</td>
<td>2.00</td>
<td>3.50</td>
<td>40</td>
<td>10</td>
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<tr>
<td>1st REF</td>
<td>99496</td>
<td>XXX</td>
<td>Transitional Care Management Services with the following</td>
<td>2018-10</td>
<td>88</td>
<td>0.051</td>
<td>0.051</td>
<td>3.79</td>
<td>75</td>
<td>75</td>
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<td></td>
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<tr>
<td>2nd REF</td>
<td>99215</td>
<td>XXX</td>
<td>Office or other outpatient visit for the evaluation and</td>
<td>2019-04</td>
<td>38</td>
<td>0.050</td>
<td>0.040</td>
<td>2.80</td>
<td>70</td>
<td>45</td>
<td>15</td>
<td></td>
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<tr>
<td>CURRENT</td>
<td>99316</td>
<td>XXX</td>
<td>Nursing facility discharge day management; more than 30 minutes</td>
<td>10/1/2010</td>
<td>191</td>
<td>0.062</td>
<td>0.048</td>
<td>2.50</td>
<td>3.01</td>
<td>3.80</td>
<td>9.00</td>
<td>63</td>
<td>8</td>
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<tr>
<td>SVY</td>
<td>99316</td>
<td>XXX</td>
<td>Nursing facility discharge day management; more than 30 minutes</td>
<td></td>
<td>107</td>
<td>0.065</td>
<td>0.050</td>
<td>2.69</td>
<td>3.50</td>
<td>3.83</td>
<td>9.00</td>
<td>70</td>
<td>15</td>
</tr>
<tr>
<td>IM &amp; FM</td>
<td>99316</td>
<td>XXX</td>
<td>NF Discharge Mgt 30 min or more</td>
<td></td>
<td>69</td>
<td>0.067</td>
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<td>0.097</td>
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<td>2.85</td>
<td>2.90</td>
<td>3.90</td>
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<td>Other, Ped and</td>
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<td>NF Discharge Mgt 30 min or more</td>
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<td>2.11</td>
<td>2.11</td>
<td>2.11</td>
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<td>3</td>
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<tr>
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<td>XXX</td>
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<td>4.50</td>
<td>50</td>
<td>10</td>
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<tr>
<td>99318 XXX</td>
<td>Evaluation and management of a patient involving an annual nursing</td>
<td>2007-02</td>
<td>0.047</td>
<td>0.036</td>
<td>1.71</td>
<td>47</td>
<td>10</td>
<td>27</td>
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<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>Global Period</td>
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</tr>
<tr>
<td>99304</td>
<td>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.</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>99305</td>
<td>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.</td>
<td>XXX</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>99306</td>
<td>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)</td>
<td>XXX</td>
<td></td>
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</tr>
<tr>
<td>99307</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
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</tr>
<tr>
<td>99308</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
<td></td>
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</tr>
<tr>
<td>99309</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99310</td>
<td>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, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)</td>
<td>XXX</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Vignette(s) *(vignette required even if PE only code(s)):*  
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.</td>
</tr>
<tr>
<td>99305</td>
<td>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.</td>
</tr>
<tr>
<td>99306</td>
<td>Initial nursing facility visit for patient with multiple morbidities requiring intensive management</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent nursing facility visit for a patient with a self-limited or minor problem</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99308</td>
<td>Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.</td>
</tr>
<tr>
<td>99309</td>
<td>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.</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.</td>
</tr>
</tbody>
</table>

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.
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.

### Post-Service

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304-99307</td>
<td>Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.</td>
</tr>
<tr>
<td>99308</td>
<td>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.</td>
</tr>
<tr>
<td>99309</td>
<td>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.</td>
</tr>
<tr>
<td>99310</td>
<td>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.</td>
</tr>
</tbody>
</table>

7. Please provide a brief description of the clinical staff work for the following:

a. **Pre-Service period:**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304-99307</td>
<td>Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.</td>
</tr>
<tr>
<td>99308</td>
<td>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.</td>
</tr>
<tr>
<td>99309</td>
<td>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.</td>
</tr>
<tr>
<td>99310</td>
<td>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.</td>
</tr>
</tbody>
</table>
Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.

### Service period (includes pre, intra and post):

- **99304**
  - **CA006 3 minutes**
    - Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.
  - **CA037 3 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.
### AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)

**PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Activity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99309</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td><strong>CA037 3 minutes</strong></td>
</tr>
<tr>
<td>99310</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td><strong>CA037 6 minutes</strong></td>
</tr>
</tbody>
</table>

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](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
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)

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.

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 Latitude 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).
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.
### AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)

#### PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

**Meeting Date:** April, 2021

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<tr>
<td>99307</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
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<tr>
<td>99308</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
</tr>
<tr>
<td>99309</td>
<td>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, XX minutes must be met or exceeded.</td>
<td>XXX</td>
</tr>
<tr>
<td>99310</td>
<td>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, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)</td>
<td>XXX</td>
</tr>
</tbody>
</table>

**Vignette(s)** *(vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.</td>
</tr>
<tr>
<td>99305</td>
<td>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.</td>
</tr>
<tr>
<td>99306</td>
<td>Initial nursing facility visit for patient with multiple morbidities requiring intensive management</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent nursing facility visit for a patient with a self-limited or minor problem</td>
</tr>
</tbody>
</table>
NON-FACILITY DIRECT PE INPUTS

CPT CODE(S): __99304-99310

SPECIALTY SOCIETY(IES): AAPM&R, ACP, AGS, AMDA, AÑA, 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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99308</td>
<td>Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.</td>
</tr>
<tr>
<td>99309</td>
<td>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.</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Non-Facility Dominant Specialties – podiatry (31.4%), family medicine (17%) and nurse practitioner (13.5%)</td>
</tr>
<tr>
<td>99305</td>
<td>Non-Facility Dominant Specialties – internal medicine (23.6%), nurse practitioner (22.6%), family medicine (19.2%)</td>
</tr>
<tr>
<td>99306</td>
<td>Non-Facility Dominant Specialties – internal medicine (38.9%), family medicine (19.1%) and nurse practitioner (17.2%)</td>
</tr>
<tr>
<td>99307</td>
<td>Non-Facility Dominant Specialties – podiatry (22.4%), nurse practitioner (20.9%), family medicine (19.1%), internal medicine (17.4%)</td>
</tr>
<tr>
<td>99308</td>
<td>Non-Facility Dominant Specialties – nurse practitioner (41.5%), internal medicine (19.1%), family medicine (15.5%)</td>
</tr>
</tbody>
</table>
If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

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

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.
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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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. |
AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99310</td>
<td>Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.</td>
</tr>
<tr>
<td>CA005</td>
<td>6 minutes</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>CA006</td>
<td>3 minutes</td>
</tr>
<tr>
<td></td>
<td>Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.</td>
</tr>
</tbody>
</table>

b. Service period (includes pre, intra and post):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td>CA037 3 minutes</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>CA038</td>
<td>8 minutes</td>
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<tr>
<td>99305</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td>CA037 3 minutes</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>CA038</td>
<td>8 minutes</td>
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<tr>
<td>99306</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td>CA037 3 minutes</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>CA038</td>
<td>8 minutes</td>
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<tr>
<td>99307</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td></td>
<td>CA037 3 minutes</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>CA038</td>
<td>8 minutes</td>
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<tr>
<td>99308</td>
<td>CA037 3 minutes</td>
</tr>
<tr>
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</tbody>
</table>
Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99309</td>
<td>CA037 3 minutes</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
<tr>
<td>99310</td>
<td>CA037 6 minutes</td>
<td>Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator.</td>
</tr>
</tbody>
</table>

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 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](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?

   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 Latitude 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
NON-FACILITY DIRECT PE INPUTS

CPT CODE(S):__99304-99310

SPECIALTY SOCIETY(IES): AAPM&R, ACP, AGS, AMDA, AÑA, 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)

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.
<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Location</th>
<th>Clinical Staff Time</th>
<th>Equipment Time</th>
<th>Facilities</th>
<th>Summary</th>
<th>Scoping</th>
<th>Signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Clinical</td>
<td>TOTAL CLINICAL STAFF TIME</td>
<td>TOTAL EQUIPMENT TIME</td>
<td>SERVICES</td>
<td>RUC</td>
<td>RUC</td>
<td>RUC</td>
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<tr>
<td>Time</td>
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<td>Per Minute</td>
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Other equipment items: to add a new equipment item please include the item consistent with the paid invoice here, type NEW in column A.

Other supply items: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A.

RUC Practice Expense Spreadsheet

Supply Code

Activity

Clinical Code

A B D E F I J K L M N O P Q R S T U V W X Y Z AA AB AC AD AE AF AG AH AI AJ AK AL AM AN AO AP AQ AR

Meeting Date: April 21, 2021

Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA
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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**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)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
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<tbody>
<tr>
<td></td>
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<td>Evaluation and Management</td>
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<td>Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services</td>
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<td>CPT Code</td>
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</table>
| 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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<th>CPT Code</th>
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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. |
| 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. |
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<th>CPT Code</th>
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</table>
| 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)

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<tr>
<th>CPT Code</th>
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| 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 |
| 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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<th>Notes</th>
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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. |
| 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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<td>(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)</td>
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<td>(Do not report 99339, 99340 during the same month with 99487-99489)</td>
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**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*.
| New Patient | 99341 | | 99342 | | 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) |
| 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) |
<table>
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<th>Description</th>
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<tbody>
<tr>
<td>99345</td>
<td>J4</td>
<td><strong>Home or residence visit</strong> 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. These 3 key components:&lt;br&gt;• A comprehensive history;&lt;br&gt;• A comprehensive examination; and&lt;br&gt;• Medical decision making of high complexity.&lt;br&gt;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.&lt;br&gt;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.&lt;br&gt;When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.&lt;br&gt;(For services ZZ minutes or longer, see prolonged services code 99417)</td>
<td>Postpone until October 2021 (2021 work RVU = 4.09)</td>
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<tr>
<td>99347</td>
<td>J5</td>
<td><strong>Home or residence visit</strong> for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making. At least 2 of these 3 key components:&lt;br&gt;• A problem-focused history;&lt;br&gt;• A problem-focused examination; and&lt;br&gt;• Straightforward medical decision making.&lt;br&gt;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.&lt;br&gt;Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.&lt;br&gt;When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</td>
<td>Postpone until October 2021 (2021 work RVU = 1.00)</td>
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| 99348   | J6       | **Home or residence 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. 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.  
When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. | XXX  
(2021 work RVU = 1.56) |
| 99349   | J7       | **Home or residence 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. 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.  
When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. | XXX  
(2021 work RVU = 2.33) |

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
| 99350 | J8 | **Home or residence 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, 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.

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, see prolonged service code 99417) | XXX | Postpone until October 2021
(2021 work RVU = 3.28) |
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).

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<td>52%</td>
<td>55%</td>
<td>72%</td>
<td>40%</td>
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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
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Page 2 of 2
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
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
</table>

**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.*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
<th>RVU</th>
<th>PE Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>99415</td>
<td>K3</td>
<td>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)</td>
<td>ZZZ</td>
<td>0.00</td>
</tr>
<tr>
<td>99416</td>
<td>K4</td>
<td>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 99415)</td>
<td>ZZZ</td>
<td>0.00</td>
</tr>
</tbody>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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:

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes (30 minutes - 1 hr. 14 min.)</td>
<td>99415 X 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)</td>
<td>99415 X 1 AND 99416 X 1</td>
</tr>
<tr>
<td>105 or more (1 hr. 45 min. or more)</td>
<td>99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Codes</th>
<th>99415 time range (minutes)</th>
<th>99416 start point (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>59-103</td>
<td>104</td>
</tr>
<tr>
<td>99203</td>
<td>64-108</td>
<td>109</td>
</tr>
<tr>
<td>99204</td>
<td>71-115</td>
<td>116</td>
</tr>
<tr>
<td>99205</td>
<td>76-120</td>
<td>121</td>
</tr>
<tr>
<td>99211</td>
<td>46-90</td>
<td>91</td>
</tr>
<tr>
<td>99212</td>
<td>54-98</td>
<td>99</td>
</tr>
<tr>
<td>99213</td>
<td>57-101</td>
<td>102</td>
</tr>
<tr>
<td>99214</td>
<td>70-114</td>
<td>115</td>
</tr>
<tr>
<td>99215</td>
<td>75-119</td>
<td>120</td>
</tr>
</tbody>
</table>

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>99415</td>
<td>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</td>
<td>ZZZ</td>
</tr>
<tr>
<td>99416</td>
<td>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</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>99415</td>
<td>A 52-year-old female presents with gastroenteritis and persistent vomiting. She presents with signs and symptoms of clinical dehydration.</td>
</tr>
<tr>
<td>99416</td>
<td>A 52-year-old female presents with gastroenteritis and persistent vomiting. She presents with signs and symptoms of clinical dehydration.</td>
</tr>
</tbody>
</table>

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?
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)

(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 provider 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.

   N/A

   c. Post-service period:

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)

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:
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)

| 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.
<table>
<thead>
<tr>
<th>Clinical Activity Code</th>
<th>Current</th>
<th>Recommended</th>
<th>Current</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>TAB: 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS</td>
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<tr>
<td>Clinical Staff Type</td>
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<tr>
<td>Clinical Staff Type Rate Per Minute</td>
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<td></td>
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</tr>
<tr>
<td>Location</td>
<td>Non Fac</td>
<td>Facility</td>
<td>Non Fac</td>
<td>Facility</td>
</tr>
<tr>
<td>Total Cost of Clinical Activity Time, Supplies and Equipment Time</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Total Clinical Staff Time</td>
<td>L0370</td>
<td>15.0</td>
<td>0.0</td>
<td>30.0</td>
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<tr>
<td>Total Pre-Service Clinical Staff Time</td>
<td>L0370</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Total Service Period Clinical Staff Time</td>
<td>L0370</td>
<td>15.0</td>
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<tr>
<td>Total Post-Service Clinical Staff Time</td>
<td>L0370</td>
<td>0.0</td>
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<tr>
<td>Total Cost of Clinical Staff Time x Rate Per Minute</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

**Pre-Service Period**
- Start: Following visit when decision for surgery/procedure made
- End: When patient enters office/facility for surgery/procedure

**Service Period**
- Start: When patient enters office/facility for surgery/procedure
- Pre-Service (of service period)
  - CPT Code 99415
- Intra-service (of service period)
  - CPT Code 99416
- Post-Service (of service period)
  - CPT Code 99417
- End: Patient leaves office/facility

**Post-Service Period**
- Start: Patient leaves office/facility
- End: with last office visit before end of global period

---

**Office visits: List Number and Level of Office Visits**
<table>
<thead>
<tr>
<th>MINUTES</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
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</thead>
<tbody>
<tr>
<td>99211</td>
<td>16 minutes</td>
<td>16</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>99212</td>
<td>27 minutes</td>
<td>27</td>
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<td>99213</td>
<td>36 minutes</td>
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<td>99214</td>
<td>45 minutes</td>
<td>45</td>
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</tr>
</tbody>
</table>

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**CPT Code 99415**
- Prolonged clinical staff service (the service beyond the highest time in the range of total time of)

**CPT Code 99416**
- Prolonged clinical staff service (the service beyond the highest time in the range of total time of)
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>RUC Collaboration Website</strong></td>
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<tr>
<td>2</td>
<td>Meeting Date: April 21, 2021</td>
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<tr>
<td>3</td>
<td>Revision Date (if applicable):</td>
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<td>4</td>
<td>Specialty: AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS</td>
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<td>6</td>
<td><strong>Clinical Staff Type Code</strong></td>
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<td>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</td>
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<td>12</td>
<td>Prolonged clinical staff service (the service beyond the highest time in the range of total time of)</td>
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<td><strong>MEDICAL SUPPLIES</strong></td>
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<td><strong>TOTAL COST OF SUPPLY QUANTITY X PRICE</strong></td>
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<td>19</td>
<td>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.</td>
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<td><strong>TOTAL COST OF EQUIPMENT TIME X COST PER MINUTE</strong></td>
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<td>22</td>
<td>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.</td>
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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 purpose 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

Decision Tree for New vs Established Patients
Initial and Subsequent Services

Some categories apply to both new and established patients (e.g., 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 (i.e., 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 (e.g., 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 (i.e., 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 (e.g., 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)

<table>
<thead>
<tr>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Elements of Medical Decision Making 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.</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
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</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Straightforward</td>
<td>Minimal • 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
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<td>Low</td>
<td>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</td>
<td>Limited <em>(Must meet the requirements of at least 1 of the 2 categories)</em> Category 1: Tests and documents • Any combination of 2 from the following: o Review of prior external note(s) from each unique source*; o Review of the result(s) of each unique test*; o Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <em>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</em></td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
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<table>
<thead>
<tr>
<th>Moderate</th>
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<tr>
<td>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or</td>
<td>• 2 or more stable, chronic illnesses; or</td>
<td>• 1 undiagnosed new problem with uncertain prognosis; or</td>
<td>• 1 acute illness with systemic symptoms; or</td>
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<tr>
<td>• 1 acute, complicated injury</td>
<td>or</td>
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<td>or</td>
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<td><strong>Moderate</strong>&lt;br&gt;<em>(Must meet the requirements of at least 1 out of 3 categories)</em>&lt;br&gt;Category 1: Tests, documents, or independent historian(s)&lt;br&gt;• Any combination of 3 from the following:&lt;br&gt;  o Review of prior external note(s) from each unique source*;&lt;br&gt;  o Review of the result(s) of each unique test*;&lt;br&gt;  o Ordering of each unique test*;&lt;br&gt;  o Assessment requiring an independent historian(s)&lt;br&gt;or&lt;br&gt;Category 2: Independent interpretation of tests&lt;br&gt;• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);&lt;br&gt;or&lt;br&gt;Category 3: Discussion of management or test interpretation&lt;br&gt;• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</td>
<td><strong>Moderate risk of morbidity from additional diagnostic testing or treatment</strong>&lt;br&gt;Examples only:&lt;br&gt;• Prescription drug management&lt;br&gt;• Decision regarding minor surgery with identified patient or procedure risk factors&lt;br&gt;• Decision regarding elective major surgery without identified patient or procedure risk factors&lt;br&gt;• Diagnosis or treatment significantly limited by social determinants of health</td>
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<td>High</td>
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<td>Extensive</td>
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| • 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 | (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:  
  o Review of prior external note(s) from each unique source*;  
  o Review of the result(s) of each unique test*;  
  o Ordering of each unique test*;  
  o 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 (e.g., 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 (e.g., 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 health 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 (e.g., 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 (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

**Independent historian(s):** An individual (e.g., 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 (e.g., 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 (e.g., 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 (e.g., 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.
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),

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
• 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.
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.

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<tr>
<th>CPT Code</th>
<th>Tracking Number</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
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<td>99483</td>
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<td>Cognitive Assessment and Care Plan Services</td>
<td>XXX</td>
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<td>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:</td>
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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 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])
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 purpose 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

Decision Tree for New vs Established Patients
Initial and Subsequent Services

Some categories apply to both new and established patients (e.g., 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 (i.e., 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>
<thead>
<tr>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Elements of Medical Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Straightforward</td>
<td>Minimal • 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Low</td>
<td>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</td>
<td>Limited (<em>Must meet the requirements of at least 1 of the 2 categories</em>) Category 1: Tests and documents • Any combination of 2 from the following: o Review of prior external note(s) from each unique source*; o Review of the result(s) of each unique test*; o Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (<em>For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high</em>)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>• 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</td>
<td>• 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</td>
<td>• 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</td>
<td>• 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</td>
</tr>
</tbody>
</table>

**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)

**Category 2: Independent interpretation of tests**

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

**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
<table>
<thead>
<tr>
<th>High</th>
<th>High</th>
</tr>
</thead>
</table>
| • 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 |

<table>
<thead>
<tr>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Must meet the requirements of at least 2 out of 3 categories)</td>
</tr>
</tbody>
</table>

**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)

**Category 2: Independent interpretation of tests**

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

**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 health 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 (e.g., 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.
CPT Code: 99483

Tracking Number L1

Original Specialty Recommended RVU: 3.80
Presented Recommended RVU: 3.50
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)

<table>
<thead>
<tr>
<th>Percent of survey respondents who stated they perform the procedure; In the hospital 0%</th>
<th>In the ASC 0%</th>
<th>In the office 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged the same day 0%</td>
<td>Overnight stay-less than 24 hours 0%</td>
<td>Overnight stay-more than 24 hours 0%</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>CPT Code: 99483</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RUC Meeting Date (mm/yyyy)</strong>: 04/2021</td>
</tr>
<tr>
<td><strong>Presenter(s):</strong> Kevin Kerber, MD; Katherine, Coerver, MD, PhD; Joshua Liao, MD; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Audrey Chun, MD; Michael Peskin, MD</td>
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<tr>
<td><strong>Specialty Society(ies):</strong> American Academy of Neurology, American College of Physicians, American Geriatrics Society</td>
</tr>
<tr>
<td><strong>CPT Code:</strong> 99483</td>
</tr>
<tr>
<td><strong>Sample Size:</strong> 2898</td>
</tr>
</tbody>
</table>

**Description of Sample:** A random sampling of active US members from each specialty society.

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
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<tbody>
<tr>
<td>Survey RVW:</td>
<td>1.10</td>
<td>3.50</td>
<td>4.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
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<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>46.00</td>
<td>60.00</td>
<td>80.00</td>
<td>150.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 15.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other hospital/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

**Specialty Recommended Pre-Service Time**

| Pre-Service Evaluation Time: | 11.00 |
| Pre-Service Positioning Time: | 0.00 |
| Pre-Service Scrub, Dress, Wait Time: | 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)

**Specialty Recommended Post-Service Time**

| Immediate Post Service-Time: | 15.00 |

---

**Notes:**

- **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)
CPT Code: 99483

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>XXX</td>
<td>3.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>90792</td>
<td>XXX</td>
<td>4.16</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>90962</td>
<td>XXX</td>
<td>3.57</td>
<td>RUC Time</td>
<td>213,048</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>49405</td>
<td>000</td>
<td>4.00</td>
<td>RUC Time</td>
<td>5,880</td>
</tr>
</tbody>
</table>

CPT **Descriptor** 2 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous.

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>95720</td>
<td>XXX</td>
<td>3.86</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 99483</th>
<th>Top Key Reference CPT Code: 99205</th>
<th>2nd Key Reference CPT Code: 90792</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>11.00</td>
<td>14.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>60.00</td>
<td>59.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>15.00</td>
<td>15.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>86.00</td>
<td>88.00</td>
<td>90.00</td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>16%</td>
<td>57%</td>
<td>24%</td>
</tr>
<tr>
<td>Mental Effort and Judgment</td>
<td>L ess</td>
<td>Identical</td>
<td>More</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>9%</td>
<td>40%</td>
<td>31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical Skill/Physical Effort</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
<td>-----------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical skill required</td>
<td>7%</td>
<td>38%</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical effort required</td>
<td>11%</td>
<td>69%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>7%</td>
<td>49%</td>
<td>44%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
</tr>
<tr>
<td>Much Less</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>8%</td>
<td>33%</td>
<td>59%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>41081</td>
<td>30.00 %</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>28757</td>
<td>21.00 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>23279</td>
<td>17.00 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>13694</td>
<td>30.00 %</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>9586</td>
<td>21.00 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>7760</td>
<td>17.00 %</td>
</tr>
</tbody>
</table>

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:
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.
### ISSUE: Cognitive Assessment and Care Plan Services

**TAB: 16**

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>RUC Review Year</th>
<th>Resp</th>
<th>WORK PER UNIT TIME</th>
<th>Total TIME</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMO</th>
<th>SURVEY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>9205</td>
<td>XXX</td>
<td>OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES</td>
<td>2019-04</td>
<td>45</td>
<td>0.048 0.040</td>
<td>3.50</td>
<td>88 14</td>
<td>59 15</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>90792</td>
<td>XXX</td>
<td>PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES</td>
<td>2012-04</td>
<td>12</td>
<td>0.058 0.046</td>
<td>4.16</td>
<td>90 10</td>
<td>60 20</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>CURRENT</td>
<td>94483</td>
<td>XXX</td>
<td>Assmt &amp; care pln pt cog imp</td>
<td>2016-04</td>
<td>74</td>
<td>0.057 0.047</td>
<td>1.10 3.50</td>
<td>4.00 4.38 60.00</td>
<td>86 11</td>
<td>5 46 60</td>
<td>80 150 15 0 0 8 50 1000</td>
</tr>
<tr>
<td>SVY-all</td>
<td>99483</td>
<td>XXX</td>
<td>Assmt &amp; care pln pt cog imp</td>
<td></td>
<td>38</td>
<td>0.053 0.044</td>
<td>1.00 3.64</td>
<td>4.00 4.48 7.50</td>
<td>90 10</td>
<td>5 53 65</td>
<td>80 120 15</td>
</tr>
<tr>
<td>AAN</td>
<td>99483</td>
<td>XXX</td>
<td>Assmt &amp; care pln pt cog imp</td>
<td></td>
<td>29</td>
<td>0.055 0.044</td>
<td>1.10 3.50</td>
<td>4.00 4.50 60.00</td>
<td>90 15</td>
<td>10 60 60</td>
<td>90 150 15</td>
</tr>
<tr>
<td>AGS</td>
<td>99483</td>
<td>XXX</td>
<td>Assmt &amp; care pln pt cog imp</td>
<td></td>
<td>7</td>
<td>0.059 0.047</td>
<td>3.00 3.28</td>
<td>3.50 3.95 4.13</td>
<td>75 10</td>
<td>35 43 50</td>
<td>58 70 15</td>
</tr>
<tr>
<td>ACP</td>
<td>99483</td>
<td>XXX</td>
<td>Assmt &amp; care pln pt cog imp</td>
<td></td>
<td>0.049 0.041</td>
<td>3.50</td>
<td>86 11</td>
<td>60 15</td>
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</table>
### 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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
</table>
| 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)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>99483</td>
<td>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</td>
</tr>
</tbody>
</table>

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.
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):

<table>
<thead>
<tr>
<th>Reference Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>99205 was selected as the reference code for practice expense as it was the key reference service chosen by respondents on the RUC survey.</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>32%</td>
</tr>
</tbody>
</table>

Neurology is dominant provide for global as well.
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):
**AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)**

**PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)**

### 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

### 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)
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:

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)

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover thermometer probe (1 item)</td>
<td>71%</td>
</tr>
<tr>
<td>Drape, non-sterile, 40in x 60 in (1 item)</td>
<td>21%</td>
</tr>
<tr>
<td>Gloves, non-sterile (2 pair)</td>
<td>78%</td>
</tr>
<tr>
<td>Gown, patient (1 item)</td>
<td>28%</td>
</tr>
<tr>
<td>Paper, exam table (7 foot)</td>
<td>86%</td>
</tr>
<tr>
<td>Patient education booklet (1 item)</td>
<td>69%</td>
</tr>
<tr>
<td>Pillowcase (1 item)</td>
<td>64%</td>
</tr>
<tr>
<td>Specula tips, otoscope (1 item)</td>
<td>53%</td>
</tr>
<tr>
<td>Swab-pad, alcohol (2 item)</td>
<td>45%</td>
</tr>
<tr>
<td>Tongue depressor (1 item)</td>
<td>48%</td>
</tr>
</tbody>
</table>

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)
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.
# RUC Practice Expense Spreadsheet

## SURVEY DATA: Total Time Medians (SAME MODEL AS E-M PE SURVEY)

**Meeting Date:** April 2021  
**Revision Date:** 4-15-21  
**Tab:** 16  
**Specialty:** AAN, ACP, AGS

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
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<tbody>
<tr>
<td><strong>REFERENCE CODE</strong></td>
<td><strong>CURRENT</strong></td>
<td><strong>RECOMMENDED</strong></td>
<td><strong>LOCATION</strong></td>
<td><strong>Non Fac</strong></td>
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<td><strong>Facility</strong></td>
<td><strong>Non Fac</strong></td>
<td><strong>Facility</strong></td>
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<tr>
<td><strong>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</strong></td>
<td><strong>TOTAL CLINICAL STAFF TIME</strong></td>
<td><strong>TOTAL PRE-SERVICE CLINICAL STAFF TIME</strong></td>
<td><strong>TOTAL SERVICE PERIOD CLINICAL STAFF TIME</strong></td>
<td><strong>TOTAL POST-SERVICE CLINICAL STAFF TIME</strong></td>
<td><strong>TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE</strong></td>
<td><strong>PRE-SERVICE PERIOD</strong></td>
<td><strong>SERVICE PERIOD</strong></td>
<td><strong>POST-SERVICE PERIOD</strong></td>
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## RUC Practice Expense Spreadsheet

**Meeting Date:** April 2021  
**Revision Date:** 4-15-21  
**Tab:** 16  
**Specialty:** AAN, ACP, AGS  

### RUC Collaboration Website

- **Clinical Activity Code:**
  - **Meeting Date:** April 2021  
  - **Revision Date:** 4-15-21  
  - **Tab:** 16  
  - **Specialty:** AAN, ACP, AGS  

### 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 independent decision making:**
  - **Reference Code:** 99205  
  - **Current:** 62

<table>
<thead>
<tr>
<th>Reference Code</th>
<th>Current</th>
<th>Recommended</th>
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<tbody>
<tr>
<td>99205</td>
<td>62</td>
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### Location

<table>
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<tr>
<th>Location</th>
<th>Non Fac</th>
<th>Facility</th>
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<tbody>
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### Clinical Staff Type

<table>
<thead>
<tr>
<th>Clinical Staff Type Code</th>
<th>Clinical Staff Type Rate Per</th>
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<tbody>
<tr>
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</table>

### Global Period

- **Total Cost of Clinical Activity Time, Supplies and Equipment Time**

<table>
<thead>
<tr>
<th>Total Cost of Clinical Activity Time, Supplies and Equipment Time</th>
<th>Location</th>
<th>Non Fac</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
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</table>

### GLOBAL PERIOD

<table>
<thead>
<tr>
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<tbody>
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</table>

### Total Clinical Staff Time

<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
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</table>

### Total Pre-Service Clinical Staff Time

<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
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</table>

### Total Service Period Clinical Staff Time

<table>
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<tr>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
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</table>

### Total Post-Service Clinical Staff Time

<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Location</th>
<th>Time</th>
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<tbody>
<tr>
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</tbody>
</table>

### Total Cost of Supply Quantity x Price

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<tr>
<th>Supply Code</th>
<th>Total Cost of Supply Quantity x Price</th>
<th>Price</th>
<th>Unit</th>
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</thead>
<tbody>
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### Equipment

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<th>Equipment Formula</th>
<th>Cost Per Minute</th>
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</table>

### Total Cost of Equipment Time x Cost Per Minute

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<tbody>
<tr>
<td>EQ189</td>
<td>66</td>
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</tr>
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<td>EF023</td>
<td>2</td>
<td>2</td>
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<td>2</td>
</tr>
<tr>
<td>EF048</td>
<td></td>
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</tbody>
</table>
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.
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.”

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
<td>090</td>
<td>7.03 (No change)</td>
</tr>
<tr>
<td>22870</td>
<td>second level (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>2.34 (No change)</td>
</tr>
</tbody>
</table>

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
CPT Code: 22869

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 22869  Tracking Number  
Global Period: 090  Current Work RVU:  7.03

Original Specialty Recommended RVU: 7.03
Presented Recommended 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.

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

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Performance Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>1.20</td>
<td>6.75</td>
<td>8.00</td>
<td>10.96</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td>45.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td>12.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>20.00</td>
<td>39.00</td>
<td>45.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

Immediate Post Service-Time: 17.00

Post Operative Visits

| Critical Care time/visit(s): | 0.00 |
| Other Hospital time/visit(s): | 0.00 |
| Discharge Day Mgmt: | 0.00 |
| Office time/visit(s): | 69.00 |
| Prolonged Services: | 0.00 |
| Sub Obs Care: | 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

| 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 |

Immediate Post Service-Time: 17.00

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 Bk/Cmplx Proc

<table>
<thead>
<tr>
<th>Pre-Service Evaluation Time:</th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33.00</td>
<td>33.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

| 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 |

Immediate Post Service-Time: 17.00

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 Bk/Cmplx Proc

<table>
<thead>
<tr>
<th>Pre-Service Evaluation Time:</th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33.00</td>
<td>33.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

| 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 |

Immediate Post Service-Time: 17.00

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)
CPT Code: 22869

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>19.00</td>
<td>99238x 0.5 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>39.00</td>
<td>99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>63655</td>
<td>090</td>
<td>10.92</td>
<td>Other</td>
</tr>
</tbody>
</table>

CPT Descriptor: Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>29880</td>
<td>090</td>
<td>7.39</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>15823</td>
<td>090</td>
<td>6.81</td>
<td>RUC Time</td>
<td>97,994</td>
</tr>
<tr>
<td>CPT Descriptor: Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MPC Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>67904</td>
<td>090</td>
<td>7.97</td>
<td>RUC Time</td>
<td>54,853</td>
</tr>
<tr>
<td>CPT Descriptor: Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>CPT Code: 22869</th>
<th>Top Key Reference CPT Code: 63655</th>
<th>2nd Key Reference CPT Code: 29880</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>58.00</td>
<td>63.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>17.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>19.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>39.0</td>
<td>62.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>178.00</td>
<td>254.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>19%</td>
<td>44%</td>
<td>26%</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>7%</td>
<td>56%</td>
<td>37%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>22%</td>
<td>52%</td>
<td>26%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>7%</td>
<td>56%</td>
<td>37%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>33%</td>
<td>48%</td>
<td>19%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>7%</td>
<td>36%</td>
<td>36%</td>
<td>21%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>14%</td>
<td>36%</td>
<td>50%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7%</td>
<td>57%</td>
<td>36%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>21%</td>
<td>29%</td>
<td>50%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>I WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
<td>7.03</td>
<td>0.076</td>
<td>178</td>
<td>63</td>
<td>45</td>
<td>17 immed 0.5-99238 1-99213 1-99212</td>
</tr>
<tr>
<td>29880</td>
<td>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.</td>
<td>7.39</td>
<td>0.065</td>
<td>199</td>
<td>58</td>
<td>45</td>
<td>15-immed 0.5-99238 2-99213 1-99212</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</td>
<td>10.92</td>
<td>0.069</td>
<td>254</td>
<td>63</td>
<td>90</td>
<td>20-immed 0.5-99238 2-99213 1-99212</td>
</tr>
</tbody>
</table>

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 Code: 22869

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
<td>6.82</td>
<td>0.072</td>
<td>161</td>
<td>17</td>
<td>45</td>
<td>10-immed 0.5-99238 1-99213 3-99212</td>
</tr>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
<td>7.03</td>
<td>0.076</td>
<td>178</td>
<td>63</td>
<td>45</td>
<td>17-immed 0.5-99238 1-99213 1-99212</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach</td>
<td>7.97</td>
<td>0.089</td>
<td>185</td>
<td>35</td>
<td>45</td>
<td>15-immed 0.5-99238 1-99213 3-99212</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>29881</td>
<td>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</td>
<td>7.03</td>
<td>0.064</td>
<td>194</td>
<td>58</td>
<td>40</td>
<td>15-immed 0.5-99238 2-99213 1-99212</td>
</tr>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
<td>7.03</td>
<td>0.076</td>
<td>178</td>
<td>63</td>
<td>45</td>
<td>17-immed 0.5-99238 1-99213 1-99212</td>
</tr>
</tbody>
</table>

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 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%
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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Pain Management</td>
<td>2093</td>
<td>30.80 %</td>
</tr>
<tr>
<td>Pain Management</td>
<td>1896</td>
<td>27.90 %</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1644</td>
<td>24.19 %</td>
</tr>
</tbody>
</table>

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:
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.
<table>
<thead>
<tr>
<th>CPT Code: 22870</th>
<th>Tracking Number</th>
<th>Original Specialty Recommended RVU: <strong>2.34</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Period: ZZZ</strong></td>
<td><strong>Current Work RVU: 2.34</strong></td>
<td>Presented Recommended RVU: <strong>2.34</strong></td>
</tr>
<tr>
<td><strong>RUC Recommended RVU: 2.34</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>David Reece, DO, Richard Rosenquist, MD, Michael Lubrano, MD, Damean Freas, MD, Kano Mayer, MD, Karin Swartz, MD</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>AAPM&amp;R, ASA, ASIPP, NANS, NASS</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>22870</td>
</tr>
</tbody>
</table>

Sample Size: 1746  Resp N: 75

Description of Sample: Targeted vendor sample and random society sample

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Evaluation Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>1.00</td>
<td>30.00</td>
<td>45.00</td>
<td>60.00</td>
<td>220.00</td>
</tr>
</tbody>
</table>

Immediate Post Service-Time: 0.00

Post Operative 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)

CPT Code: 22870

Recommended Physician Work RVU: 2.34

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>22870</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>45.00</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>Speciality Recommended Post-Service Time</th>
<th>Speciality Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

ZZZ Global Code
CPT Code: 22870

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22515</td>
<td>ZZZ</td>
<td>4.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>63048</td>
<td>ZZZ</td>
<td>3.47</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>36476</td>
<td>ZZZ</td>
<td>2.65</td>
<td>RUC Time</td>
<td>7,170</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>15772</td>
<td>ZZZ</td>
<td>2.50</td>
<td>RUC Time</td>
<td></td>
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</tbody>
</table>

CPT Descriptor 2 Other Reference CPT Code
CPT Code: 22870

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 22870</th>
<th>Top Key Reference CPT Code: 22515</th>
<th>2nd Key Reference CPT Code: 63048</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>45.00</td>
<td>30.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>45.00</td>
<td>32.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>14%</td>
<td>35%</td>
<td>37%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>26%</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td>Technical Skill/Physical Effort</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>Technical skill required</td>
<td>9%</td>
<td>59%</td>
<td>32%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>6%</td>
<td>54%</td>
<td>40%</td>
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</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>17%</td>
<td>49%</td>
<td>34%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>8%</td>
<td>54%</td>
<td>23%</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>15%</td>
<td>46%</td>
<td>39%</td>
</tr>
<tr>
<td>• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>31%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>8%</td>
<td>25%</td>
<td>67%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The risk of significant complications, morbidity and/or mortality</td>
<td>39%</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td>• Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)).*

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22870</td>
<td><strong>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)</strong></td>
<td>2.34</td>
<td>0.052</td>
<td>45</td>
<td></td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>63048</td>
<td><strong>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).</strong></td>
<td>3.48</td>
<td>0.077</td>
<td>45</td>
<td></td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>22515</td>
<td><strong>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).</strong></td>
<td>4.00</td>
<td>0.132</td>
<td>32</td>
<td>1</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>22870</td>
<td><strong>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance</strong></td>
<td>2.34</td>
<td>0.052</td>
<td>45</td>
<td></td>
<td></td>
<td>45</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>15772</td>
<td>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)</td>
<td>2.50</td>
<td>.055</td>
<td>45</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22870</td>
<td>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)</td>
<td>2.34</td>
<td>0.052</td>
<td>45</td>
<td>45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary

The societies recommend for CPT code 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 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.
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Pain Management</td>
<td>Rarely</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Rarely</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Pain Management</td>
<td>2890</td>
<td>33.40 %</td>
</tr>
<tr>
<td>Pain Management</td>
<td>2509</td>
<td>28.99 %</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>2007</td>
<td>23.19 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Pain Management</td>
<td>963</td>
<td>33.39 %</td>
</tr>
<tr>
<td>Pain Management</td>
<td>836</td>
<td>28.98 %</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>669</td>
<td>23.19 %</td>
</tr>
</tbody>
</table>

Do many physicians perform this service across the United States? No
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**

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
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<th>Resp</th>
<th>IMPUT Year Time</th>
<th>Work Per Unit Time</th>
<th>RVW</th>
<th>Total PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMD</th>
<th>FAC-inpt/same day</th>
<th>Office</th>
<th>SURVEY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>63055</td>
<td>90</td>
<td>Laminectomy for resection of neurostimulator electrodes, bilateral medially</td>
<td>2010</td>
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<td>2nd REF</td>
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<td>2011</td>
<td>0.065</td>
<td>0.037</td>
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<tr>
<td>CURRENT</td>
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<td>15</td>
<td>43</td>
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<tr>
<td>SVY</td>
<td>22869</td>
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<td>process stabilization/distraction device, without open decompression or fusion, insertion prone, cervical spine</td>
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</tr>
<tr>
<td>Random Society Sample</td>
<td>22869</td>
<td>90</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, including image guidance when performed, lumbar; single level</td>
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<td></td>
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<td></td>
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<tr>
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<td>22869</td>
<td>90</td>
<td>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)</td>
<td></td>
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</tbody>
</table>

**Source CPT Global DESC**

**RUC Review Year**

**Resp**

**IMPUT Year Time**

**Work Per Unit Time**

**RVW**

**Total**

**PRE-TIME**

**INTRA-TIME**

**IMMD**

**FAC-inpt/same day**

**Office**

**SURVEY EXPERIENCE**

**PRE-TIME RVW INTRA-TIME IMMD FAC-inpt/same day Office SURVEY EXPERIENCE**

| 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) | 2013 | 0.077 | 0.077 | 3.47 | 45 | 45 | 45 | 45 |
| CURRENT | 22870 | ZZZ | Insertion of interlaminar/interspinous process stabilization/distraction device | 2017 | 0.078 | 0.078 | 2.34 | 30 | 30 | 30 | 30 |
| SVY | 22870 | ZZZ | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level | | | | | | | | | | | |
| Targeted Vendor List | 22870 | ZZZ | | | | | | | | | | | |
| Random Society Sample | 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) | | | | | | | | | | | |
| 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) | | | | | | | | | | | |
### 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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
<td>090</td>
</tr>
<tr>
<td>22870</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

**Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>22869</td>
<td>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.</td>
</tr>
<tr>
<td>22870</td>
<td>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.</td>
</tr>
</tbody>
</table>

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
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:

<table>
<thead>
<tr>
<th><strong>For code 22869</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete pre-service diagnostic and referral forms</strong></td>
</tr>
<tr>
<td><strong>Coordinate pre-surgery services (including test results)</strong></td>
</tr>
<tr>
<td><strong>Schedule space and equipment in facility</strong></td>
</tr>
<tr>
<td><strong>Provide pre-service education/obtain consent</strong></td>
</tr>
<tr>
<td><strong>Complete pre-procedure phone calls and prescription</strong></td>
</tr>
</tbody>
</table>

b. Service period (includes pre, intra and post):

<table>
<thead>
<tr>
<th><strong>6 minutes (standard)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as:</td>
</tr>
<tr>
<td>• Responding to patient/family questions about home activity restrictions/WB status, therapy questions</td>
</tr>
<tr>
<td>• Telephonic or electronic communication assistance with the office, and other necessary management assistance related to the hospitalization.</td>
</tr>
</tbody>
</table>
• 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Unit</th>
<th>Item</th>
<th>Qty</th>
<th>Unit price</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA048</td>
<td>pack</td>
<td>paper, exam table</td>
<td>foot</td>
<td>2.1122</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gloves, non-sterile</td>
<td>pair</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gown, patient</td>
<td>item</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pillow case</td>
<td>item</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cover, thermometer probe</td>
<td>item</td>
<td>1</td>
</tr>
</tbody>
</table>

### DESCRIPTION

<table>
<thead>
<tr>
<th>Code</th>
<th>Unit</th>
<th>Item</th>
<th>Qty</th>
<th>Unit price</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA052</td>
<td>pack</td>
<td>kit, staple removal</td>
<td>kit</td>
<td>4.992</td>
</tr>
<tr>
<td></td>
<td></td>
<td>povidone soln (Betadine)</td>
<td>ml</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gauze, sterile 4in x 4in</td>
<td>item</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gloves, sterile</td>
<td>pair</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>steri-strip (6 strip uou)</td>
<td>item</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>swab-pad, alcohol</td>
<td>item</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tape, surgical paper 1in (Micropore)</td>
<td>inch</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tincture of benzoin, swab</td>
<td>item</td>
<td>1</td>
</tr>
</tbody>
</table>

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 Latitude 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Item</th>
<th>Time is equal to office visit total time based on current database time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EF031</td>
<td>table, power</td>
<td>Time is equal to office visit total time based on current database time.</td>
</tr>
</tbody>
</table>

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
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)

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.
<table>
<thead>
<tr>
<th>Clinical Activity Code</th>
<th>Clinical Staff Type</th>
<th>Clinical Staff Type Code</th>
<th>Insertion of intermittent /</th>
<th>Insertion of intermittent /</th>
<th>Insertion of intermittent /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>interspinous process</td>
<td>interspinous process</td>
<td>interspinous process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>stabilization / distractio</td>
<td>stabilization / distractio</td>
<td>stabilization / distractio</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n device, without</td>
<td>n device, without</td>
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**GLOBAL PERIOD**

<table>
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</tbody>
</table>

**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**

<table>
<thead>
<tr>
<th>PRE-SERVICE PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start: Following visit when decision for surgery/procedure made</td>
</tr>
<tr>
<td>End: When patient enters office/facility for surgery/procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SERVICE PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start: When patient enters office/facility for surgery/procedure:</td>
</tr>
<tr>
<td>End: Patient leaves office/facility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINUTES</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
<th># visits</th>
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<tbody>
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</tr>
</tbody>
</table>

**OTHER ACTIVITY:**

- Procedure performed following and/or before procedure listed above
- Procedure performed on the same day as procedure listed above
- Procedure performed on the same day as procedure listed above

**TOTAL COST OF CLINICAL ACTIVITY TIME & RATE PER MINUTE**

<table>
<thead>
<tr>
<th>Location</th>
<th>Tab: 17</th>
<th>RUC Collaboration Website</th>
<th>Clinical</th>
<th>L037D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RECOMMENDED**

- Facility
- RUC Practice Expense Spreadsheet
- Activity Code
- Clinical
- RUC Collaboration Website

**END:**

- with last office visit before end of global period
Meeting Date: April 21, 2021
Revision Date (if applicable):

<table>
<thead>
<tr>
<th>Clinical Activity Code</th>
<th>Clinical Staff Type</th>
<th>090</th>
<th>090</th>
<th>090</th>
<th>090</th>
<th>ZZZ</th>
<th>ZZZ</th>
<th>ZZZ</th>
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</thead>
<tbody>
<tr>
<td>GLOBAL PERIOD</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</td>
<td>L037D</td>
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<td>120.0</td>
<td>0.0</td>
<td>120.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL PRE-SERVICE CLINICAL STAFF TIME</td>
<td>L037D</td>
<td>0.0</td>
<td>60.0</td>
<td>0.0</td>
<td>60.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>TOTAL SERVICE PERIOD CLINICAL STAFF TIME</td>
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<td>0.0</td>
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<td>0.0</td>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL POST-SERVICE CLINICAL STAFF TIME</td>
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<td>0.0</td>
<td>63.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>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.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Supply Code</th>
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<th>PRICE</th>
<th>UNIT</th>
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<tr>
<td>101</td>
<td>SA04S</td>
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<td>2</td>
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<td>102</td>
<td>SA04H</td>
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<td></td>
</tr>
</tbody>
</table>

| 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. |

<table>
<thead>
<tr>
<th>Equipment Code</th>
<th>EQUIPMENT</th>
<th>Purchase Price</th>
<th>Equipment Formula</th>
<th>Cost Per Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>EF33D</td>
<td>Office Visit</td>
<td>63.0</td>
<td>63.0</td>
</tr>
<tr>
<td>104</td>
<td>EF33E</td>
<td>Office Visit</td>
<td>63.0</td>
<td>63.0</td>
</tr>
</tbody>
</table>

| 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. |
In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 with Medicare data from 2017-2019 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.
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 99214 for both.
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:

<table>
<thead>
<tr>
<th></th>
<th>27446 (UKA)</th>
<th>27447 (THA)</th>
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<tbody>
<tr>
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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).

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
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<tbody>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
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<td>17.13</td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>090</td>
<td>19.60 (Affirmed October 2019 RUC recommendation)</td>
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</table>
CPT Code: 27446

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27446 Tracking Number Original Specialty Recommended RVU: 17.13
Global Period: 090 Current Work RVU: 17.48 Presented Recommended RVU: 17.13
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 administration 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; complete medication reconciliation; 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 medications; renew, 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 reconciliation; 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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Adolph Yates, MD; William Creevy, MD; Hussein Elkousy, MD</td>
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<tr>
<td>Specialty Society(ies):</td>
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**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)

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<td>CPT Code: 27446</td>
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<td>Recommended Physician Work RVU: 17.13</td>
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| Pre-Service Evaluation Time: 40.00 | Pre-Service Positioning Time: 15.00 | Pre-Service Scrub, Dress, Wait 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)

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<thead>
<tr>
<th>9B General Anes or Complex Regional Blk/Cmplx Proc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time: 45.00</td>
</tr>
<tr>
<td>Post-Operative Visits</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Critical Care/visit(s):</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
</tr>
<tr>
<td>Prolonged Services:</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>090</td>
<td>19.60</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>23472</td>
<td>090</td>
<td>22.13</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>19303</td>
<td>090</td>
<td>15.00</td>
<td>RUC Time</td>
<td>25,487</td>
</tr>
</tbody>
</table>

CPT Descriptor 1: Mastectomy, simple, complete

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37215</td>
<td>090</td>
<td>17.75</td>
<td>RUC Time</td>
<td>10,340</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>67107</td>
<td>090</td>
<td>16.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 27446</th>
<th>Top Key Reference CPT Code: 27130</th>
<th>2nd Key Reference CPT Code: 23472</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>70.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>90.00</td>
<td>100.00</td>
<td>140.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>45.00</td>
<td>20.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>80.00</td>
<td>80.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>19.0</td>
<td>38.00</td>
<td>38.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>86.00</td>
<td>69.00</td>
<td>85.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>310.00</td>
<td>377.00</td>
<td>448.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES
(OF THOSE THAT SELECTED KEY REFERENCE CODES)
Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>11%</td>
<td>59%</td>
<td>27%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Effort and Judgment</td>
<td>3%</td>
<td>58%</td>
<td>39%</td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>38%</td>
<td>49%</td>
<td>13%</td>
</tr>
</tbody>
</table>

|                             |      |           |      |
| Physical effort required    | 8%   | 61%       | 31%  |
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>8%</td>
<td>58%</td>
<td>34%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>81%</td>
<td>14%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>0%</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>5%</td>
<td>76%</td>
<td>19%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>0%</td>
<td>81%</td>
<td>19%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th></th>
<th>Crosswalk Comparison</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27446</td>
<td>67108</td>
<td></td>
</tr>
<tr>
<td>Uni-knee</td>
<td>Uni-knee joint replacement</td>
<td>Repair retinal detachment</td>
<td></td>
</tr>
<tr>
<td>wRVU</td>
<td>17.13</td>
<td>17.13</td>
<td></td>
</tr>
<tr>
<td>2019 Utilization</td>
<td>15,803</td>
<td>16,523</td>
<td></td>
</tr>
<tr>
<td>Facility Status</td>
<td>typically admitted or overnight</td>
<td>typically same-day discharge</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>31%</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hosp</td>
<td>31%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>ASC</td>
<td>18%</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Pre-time</td>
<td>70 (package 4)</td>
<td>51 (package 3)</td>
<td></td>
</tr>
<tr>
<td>Intra-time</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Immed post time</td>
<td>45</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Other Hosp time</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Discharge day</td>
<td>0.5 x 99238²</td>
<td>0.5 x 99238³</td>
<td></td>
</tr>
<tr>
<td>Office visit time</td>
<td>86</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>Total time</td>
<td>310</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>IWPUT</td>
<td>0.119</td>
<td>0.114</td>
<td></td>
</tr>
<tr>
<td>WPNOT</td>
<td>0.055</td>
<td>0.058</td>
<td></td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review PT/OT and/or rehab/SNF/VNA notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>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</td>
<td>1-2</td>
</tr>
<tr>
<td>3. Discuss findings at surgery and review procedure details; answer questions</td>
<td>2</td>
</tr>
<tr>
<td>4. Review post-operative radiographs with patient and/or family</td>
<td></td>
</tr>
<tr>
<td>5. Interview patient and obtain history and/or review data obtained by clinical staff</td>
<td></td>
</tr>
<tr>
<td>6. Assess pain control, response to current medications and side-effects</td>
<td></td>
</tr>
<tr>
<td>7. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td>2-3</td>
</tr>
<tr>
<td>8. Assess gastrointestinal and urinary function to assess for medication side effects</td>
<td></td>
</tr>
<tr>
<td>9. Remove dressing; examine surgical site</td>
<td></td>
</tr>
<tr>
<td>10. Assess limb alignment, swelling, strength and ROM</td>
<td>3-3</td>
</tr>
<tr>
<td>11. Check neurovascular status</td>
<td></td>
</tr>
<tr>
<td>12. Remove sutures or staples; apply steri-strips, sterile dressing and compressive wrap or stockings</td>
<td>4</td>
</tr>
<tr>
<td>13. Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)</td>
<td></td>
</tr>
<tr>
<td>14. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet</td>
<td>3</td>
</tr>
<tr>
<td>15. Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering</td>
<td></td>
</tr>
<tr>
<td>16. Check narcotic prescription registries</td>
<td></td>
</tr>
<tr>
<td>17. Write order for narcotic prescription; re-fill or new medication</td>
<td></td>
</tr>
<tr>
<td>18. Write order for non-narcotic prescription as appropriate (e.g. NSAIDs, gabapentin)</td>
<td>4</td>
</tr>
<tr>
<td>19. Write order for prescriptions for continued VTE prophylaxis based on patient risk assessment and mobilization; re-fill or new medication</td>
<td></td>
</tr>
<tr>
<td>20. Complete medication reconciliation</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>2-3</td>
</tr>
<tr>
<td>22. Complete forms/referrals for continued PT/OT and/or home care services (e.g. VNA)</td>
<td>2-3</td>
</tr>
<tr>
<td>23. Complete disability, FMLA, out of/return to work and other related forms</td>
<td></td>
</tr>
<tr>
<td>24. Communicate and coordinate care with other physicians and health care providers (e.g., PT/OT, PCP)</td>
<td>2-3</td>
</tr>
<tr>
<td>25. Enter diagnosis code(s) and office visit codes in the EHR or other similar system</td>
<td>4</td>
</tr>
<tr>
<td>26. Write or dictate and sign progress note</td>
<td></td>
</tr>
<tr>
<td>27. Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)</td>
<td>2-3</td>
</tr>
</tbody>
</table>

**TOTAL TIME** 32-40  
**REQUIRED TIME** 30-39

## OFFICE VISIT #2: six weeks after surgery (LOS = 99213)

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review PT/OT notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>2. Interview patient and obtain history and/or review data obtained by clinical staff</td>
<td></td>
</tr>
<tr>
<td>3. Assess pain control, response to current medications and side-effects</td>
<td></td>
</tr>
<tr>
<td>4. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td>3</td>
</tr>
<tr>
<td>5. Assess gastrointestinal to assess for medication side effects</td>
<td></td>
</tr>
<tr>
<td>6. Examine surgical site; assess wound healing and signs of infection</td>
<td></td>
</tr>
<tr>
<td>7. Assess limb alignment, swelling, strength and ROM</td>
<td>2-3</td>
</tr>
<tr>
<td>8. Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)</td>
<td></td>
</tr>
<tr>
<td>9. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet</td>
<td>3</td>
</tr>
<tr>
<td>10. Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering</td>
<td></td>
</tr>
</tbody>
</table>
11. Write order for non-narcotic prescription as appropriate (e.g. NSAIDs) 2-3

12. Complete medication reconciliation

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

15. Complete disability, FMLA, out of/return to work and other related forms 2-3

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)**

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review PT/OT notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>2. Interview patient and obtain history and/or review data obtained by clinical staff</td>
<td></td>
</tr>
<tr>
<td>3. Assess pain control, response to current medications and side-effects</td>
<td>3</td>
</tr>
<tr>
<td>4. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td></td>
</tr>
<tr>
<td>5. Examine surgical site; assess wound healing and signs of infection</td>
<td></td>
</tr>
<tr>
<td>6. Assess limb alignment, swelling, strength and ROM</td>
<td>2-3</td>
</tr>
<tr>
<td>7. Review radiographs; independent interpretation</td>
<td>2-3</td>
</tr>
<tr>
<td>8. Counsel patient and/or family regarding therapy protocol and activity (e.g. driving, exercise, sports)</td>
<td>2-3</td>
</tr>
<tr>
<td>9. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet</td>
<td>2-3</td>
</tr>
<tr>
<td>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</td>
<td>2-3</td>
</tr>
<tr>
<td>11. Complete forms/referrals for continued PT/OT</td>
<td>2-3</td>
</tr>
<tr>
<td>12. Complete disability, FMLA, out of/return to work and other related forms</td>
<td>2-3</td>
</tr>
<tr>
<td>13. Enter diagnosis code(s) and office visit codes in the EHR or other similar system</td>
<td>4</td>
</tr>
<tr>
<td>14. Write or dictate and sign progress note</td>
<td></td>
</tr>
<tr>
<td>15. Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)</td>
<td>2-3</td>
</tr>
</tbody>
</table>

**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).
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.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
<td>17.13</td>
<td>0.119</td>
<td>310</td>
<td>70</td>
<td>90</td>
<td>150</td>
</tr>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>19.60</td>
<td>0.109</td>
<td>377</td>
<td>70</td>
<td>100</td>
<td>207</td>
</tr>
<tr>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)).</td>
<td>22.13</td>
<td>0.089</td>
<td>448</td>
<td>75</td>
<td>140</td>
<td>233</td>
</tr>
</tbody>
</table>

MPC Code Comparison

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
<td>15.00</td>
<td>0.102</td>
<td>283</td>
<td>58</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
<td>17.13</td>
<td>0.119</td>
<td>310</td>
<td>70</td>
<td>90</td>
<td>150</td>
</tr>
<tr>
<td>37215</td>
<td>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</td>
<td>17.75</td>
<td>0.109</td>
<td>322</td>
<td>80</td>
<td>103</td>
<td>139</td>
</tr>
</tbody>
</table>
Other Code Comparison

Codes 63620 and 67108 bracket and offer further support of the recommended wRVU of 17.13 for 27446.

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>WPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>63620</td>
<td>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion</td>
<td>15.60</td>
<td>0.136</td>
<td>195</td>
<td>25</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
<td>17.13</td>
<td>0.119</td>
<td>310</td>
<td>70</td>
<td>90</td>
<td>150</td>
</tr>
<tr>
<td>67108</td>
<td>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</td>
<td>17.13</td>
<td>0.114</td>
<td>295</td>
<td>51</td>
<td>90</td>
<td>154</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic surgery</td>
<td>Commonly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic surgery</td>
<td>15567</td>
<td>98.50 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Review PT/OT and/or rehab/SNF/VNA notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>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</td>
<td>1-2</td>
</tr>
<tr>
<td>30. Discuss findings at surgery and review procedure details; answer questions</td>
<td>2</td>
</tr>
<tr>
<td>31. Review post-operative radiographs with patient and/or family</td>
<td>2</td>
</tr>
<tr>
<td>32. Assess pain control, response to current medications and side-effects</td>
<td>2-3</td>
</tr>
<tr>
<td>33. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td>2-3</td>
</tr>
<tr>
<td>34. Assess gastrointestinal and urinary function to assess for medication side effects</td>
<td></td>
</tr>
<tr>
<td>35. Remove dressing; examine surgical site</td>
<td>3-3</td>
</tr>
<tr>
<td>36. Check neurovascular status</td>
<td>4</td>
</tr>
<tr>
<td>37. Remove sutures or staples; apply sti-ri-strips, sterile dressing and compressive wrap or stockings</td>
<td>3</td>
</tr>
<tr>
<td>38. Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)</td>
<td>3</td>
</tr>
<tr>
<td>39. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet</td>
<td>3</td>
</tr>
<tr>
<td>40. Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering</td>
<td>3</td>
</tr>
<tr>
<td>41. Check narcotic prescription registries</td>
<td>4</td>
</tr>
<tr>
<td>42. Write order for narcotic prescription; re-fill or new medication</td>
<td>4</td>
</tr>
<tr>
<td>43. Write order for non-narcotic prescription as appropriate (e.g. NSAIDs, gabapentin)</td>
<td>4</td>
</tr>
<tr>
<td>44. Write order for prescriptions for continued VTE prophylaxis based on patient risk assessment and mobilization; re-fill or new medication</td>
<td>4</td>
</tr>
<tr>
<td>45. Complete medication reconciliation</td>
<td>4</td>
</tr>
<tr>
<td>46. 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</td>
<td>2-3</td>
</tr>
<tr>
<td>47. Complete forms/referrals for continued PT/OT and/or home care services (e.g. VNA)</td>
<td>2-3</td>
</tr>
<tr>
<td>48. Complete disability, FMLA, out of/return to work and other related forms</td>
<td>2-3</td>
</tr>
<tr>
<td>49. Communicate and coordinate care with other physicians and health care providers (e.g., PT/OT, PCP)</td>
<td>2-3</td>
</tr>
<tr>
<td>50. Enter diagnosis code(s) and office visit codes in the EHR or other similar system</td>
<td>4</td>
</tr>
<tr>
<td>51. Write or dictate and sign progress note</td>
<td>2-3</td>
</tr>
<tr>
<td>52. Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)</td>
<td>2-3</td>
</tr>
</tbody>
</table>

**TOTAL TIME** 32-40

**REQUIRED TIME** 30-39

## OFFICE VISIT #2: six weeks after surgery (LOS = 99213)

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Review PT/OT notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>21. Interview patient and obtain history and/or review data obtained by clinical staff</td>
<td>1-2</td>
</tr>
<tr>
<td>22. Assess pain control, response to current medications and side-effects</td>
<td>2</td>
</tr>
<tr>
<td>23. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td>2-3</td>
</tr>
<tr>
<td>24. Assess gastrointestinal to assess for medication side effects</td>
<td>3</td>
</tr>
<tr>
<td>25. Examine surgical site; assess wound healing and signs of infection</td>
<td>3</td>
</tr>
<tr>
<td>26. Assess limb alignment, swelling, strength and ROM</td>
<td>3</td>
</tr>
<tr>
<td>27. Counsel patient and/or family regarding wound care, therapy protocol and activity (e.g. driving, bathing, leg elevation)</td>
<td>3-3</td>
</tr>
<tr>
<td>28. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental,</td>
<td>3-3</td>
</tr>
</tbody>
</table>
GI) about need for prophylactic antibiotics; review instruction sheet

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>29.</td>
<td>Counsel patient/family regarding multi-modal pain management and use of narcotic pain medication with tapering</td>
</tr>
<tr>
<td>30.</td>
<td>Write order for non-narcotic prescription as appropriate (e.g. NSAIDs)</td>
</tr>
<tr>
<td>31.</td>
<td>Complete medication reconciliation</td>
</tr>
<tr>
<td>32.</td>
<td>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</td>
</tr>
<tr>
<td>33.</td>
<td>Complete forms/referrals for continued PT/OT</td>
</tr>
<tr>
<td>34.</td>
<td>Complete disability, FMLA, out of/return to work and other related forms</td>
</tr>
<tr>
<td>35.</td>
<td>Enter diagnosis code(s) and office visit codes in the EHR or other similar system</td>
</tr>
<tr>
<td>36.</td>
<td>Order radiographs for next visit</td>
</tr>
<tr>
<td>37.</td>
<td>Write or dictate and sign progress note</td>
</tr>
<tr>
<td>38.</td>
<td>Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)</td>
</tr>
</tbody>
</table>

**TOTAL TIME** 21-27  
**REQUIRED TIME** 20-29

**OFFICE VISIT #3: ten weeks after surgery (LOS = 99213)**

<table>
<thead>
<tr>
<th>Work completed by the physician and/or QHP</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Review PT/OT notes to assess progress with therapy</td>
<td>1-2</td>
</tr>
<tr>
<td>17. Interview patient and obtain history and/or review data obtained by clinical staff</td>
<td>3</td>
</tr>
<tr>
<td>18. Assess pain control, response to current medications and side-effects</td>
<td></td>
</tr>
<tr>
<td>19. Assess function, mobility and progress with ambulation; compare with reports from PT/OT/rehab</td>
<td>2-3</td>
</tr>
<tr>
<td>20. Examine surgical site; assess wound healing and signs of infection</td>
<td></td>
</tr>
<tr>
<td>21. Assess limb alignment, swelling, strength and ROM</td>
<td></td>
</tr>
<tr>
<td>22. Review radiographs; independent interpretation</td>
<td>2-3</td>
</tr>
<tr>
<td>23. Counsel patient and/or family regarding therapy protocol and activity (e.g. driving, exercise, sports)</td>
<td>2-3</td>
</tr>
<tr>
<td>24. Counsel patient and/or family regarding planned or emergent invasive procedures (e.g. dental, GI) about need for prophylactic antibiotics; review instruction sheet</td>
<td>2-3</td>
</tr>
<tr>
<td>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</td>
<td>2-3</td>
</tr>
<tr>
<td>26. Complete forms/referrals for continued PT/OT</td>
<td>2-3</td>
</tr>
<tr>
<td>27. Complete disability, FMLA, out of/return to work and other related forms</td>
<td></td>
</tr>
<tr>
<td>28. Enter diagnosis code(s) and office visit codes in the EHR or other similar system</td>
<td>4</td>
</tr>
<tr>
<td>29. Write or dictate and sign progress note</td>
<td></td>
</tr>
<tr>
<td>30. Enter post-operative data into longitudinal outcome registries (e.g. NSQIP, AJRR, and/or local registry)</td>
<td>2-3</td>
</tr>
</tbody>
</table>

**TOTAL TIME** 22-29  
**REQUIRED TIME** 20-29
### ISSUE: Knee Arthroplasty

**TAB: 18**

<table>
<thead>
<tr>
<th>Source</th>
<th>Year</th>
<th>CPT</th>
<th>DESC</th>
<th>Glob</th>
<th>Resp</th>
<th>WPUT</th>
<th>WPUT</th>
<th>RVW</th>
<th>PRE</th>
<th>INTRA</th>
<th>IRG</th>
<th>POST Facility</th>
<th>POST-Office</th>
<th>12 Month Svy Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>REF1</td>
<td>2019</td>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthesis</td>
<td>90</td>
<td>71</td>
<td>0.108</td>
<td>0.052</td>
<td>19.65</td>
<td>377</td>
<td>40</td>
<td>15</td>
<td>15</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>REF2</td>
<td>2012</td>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint; total shoulder (hip)</td>
<td>90</td>
<td>21</td>
<td>0.089</td>
<td>0.049</td>
<td>22.13</td>
<td>448</td>
<td>40</td>
<td>15</td>
<td>20</td>
<td>140</td>
<td>30</td>
</tr>
<tr>
<td>Current</td>
<td>2013</td>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial</td>
<td>90</td>
<td>109</td>
<td>0.051</td>
<td>17.48</td>
<td>345</td>
<td>40</td>
<td>15</td>
<td>20</td>
<td>90</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>SVY</td>
<td>2021</td>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial</td>
<td>90</td>
<td>126</td>
<td>0.127</td>
<td>0.055</td>
<td>14.50</td>
<td>18.60</td>
<td>15.65</td>
<td>21.00</td>
<td>26.69</td>
<td>354</td>
<td>45</td>
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<td>REC</td>
<td>2015</td>
<td>27446</td>
<td>Crosswalk to RVW for 67108</td>
<td>90</td>
<td>0.119</td>
<td>0.055</td>
<td>17.13</td>
<td>310</td>
<td>40</td>
<td>15</td>
<td>15</td>
<td>90</td>
<td>45</td>
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<tr>
<td>XWALK</td>
<td>2015</td>
<td>67108</td>
<td>Repair of retinal detachment; with vitrectomy, anular</td>
<td>90</td>
<td>0.114</td>
<td>0.058</td>
<td>17.13</td>
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<td>33</td>
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**CURRENT**

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<th>Resp</th>
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<th>WPUT</th>
<th>RVW</th>
<th>PRE</th>
<th>INTRA</th>
<th>IRG</th>
<th>POST Facility</th>
<th>POST-Office</th>
<th>12 Month Svy Experience</th>
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<tbody>
<tr>
<td>2019</td>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial</td>
<td>90</td>
<td>0.112</td>
<td>0.052</td>
<td>19.60</td>
<td>377</td>
<td>40</td>
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**AFFIRM**

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<th>RVW</th>
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<th>INTRA</th>
<th>IRG</th>
<th>POST Facility</th>
<th>POST-Office</th>
<th>12 Month Svy Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial</td>
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<td>15</td>
<td>15</td>
<td>97</td>
<td>20</td>
<td>2</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
<td>090</td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>090</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>27446</td>
<td>A 67-year-old obese female (BMI &gt; 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.</td>
</tr>
<tr>
<td>27447</td>
<td>A 74-year-old female has knee osteoarthritis not responding to nonoperative treatment. A total knee arthroplasty (TKA) is performed.</td>
</tr>
</tbody>
</table>

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:
7. Please provide a brief description of the clinical staff work for the following:

   a. Pre-Service period:

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete pre-service diagnostic and referral forms</td>
<td>Staff reviews all forms with patient and/or caregiver to ensure all relevant history and diagnostic information is included</td>
</tr>
<tr>
<td>Coordinate pre-surgery services (including test results)</td>
<td>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.</td>
</tr>
<tr>
<td>Schedule space and equipment in facility</td>
<td>Staff interacts with facility to schedule space, supplies, equipment, and review checklists</td>
</tr>
<tr>
<td>Provide pre-service education/obtain consent</td>
<td>Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.</td>
</tr>
<tr>
<td>Complete pre-procedure phone calls and prescription</td>
<td>Staff reviews preoperative medication changes, reviews patient medical status, confirms preoperative cleansing protocol, and answers final pre-admission questions.</td>
</tr>
</tbody>
</table>

   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 current (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](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?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA048</td>
<td>pack, minimum multi-specialty visit</td>
</tr>
<tr>
<td>SA052</td>
<td>pack, post-op incision care (staple)</td>
</tr>
</tbody>
</table>

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](http://www.bls.gov) for information on the contents of kits, packs and trays.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Code</th>
<th>Unit</th>
<th>Item Qty</th>
<th>Unit price</th>
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</thead>
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<tr>
<td>pack, minimum multi-specialty visit</td>
<td>SA048</td>
<td>pack</td>
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<td>4.0507</td>
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<tr>
<td>paper, exam table</td>
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<td>7</td>
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<tr>
<td>gloves, non-sterile</td>
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<td>gown, patient</td>
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<td>pillow case</td>
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<td></td>
</tr>
<tr>
<td>cover, thermometer probe</td>
<td></td>
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</tr>
</tbody>
</table>
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 Latitude 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:

| 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

n/a
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.
<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
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<tr>
<td>2</td>
<td>Meeting Date: 04/2021</td>
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</table>
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.**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
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<tbody>
<tr>
<td>27446</td>
<td>Arthroplasty, knee, condyle and plateau; medial OR lateral compartment</td>
<td>090</td>
<td>Request to Survey April 2021 RUC Meeting</td>
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</tbody>
</table>

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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
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.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.
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 osteophysectomy: 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
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.
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 25\(^\text{th}\) 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 PE 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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>090</td>
<td>19.60</td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>090</td>
<td>19.60</td>
</tr>
</tbody>
</table>
CPT Code: 27130

Tracking Number

Original Specialty Recommended RVU: 20.72
Presented Recommended 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; counseling 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,
CPT Code: 27130

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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>10/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>William Creevy, MD, AAOS RUC Advisor; Hussein Elkousy, MD, AAOS RUC Alternate Advisor; Adolph Yates, MD, AAHKS</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Academy of Orthopaedic Surgery (AAOS); American Association of Hip and Knee Surgeons (AAHKS)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>27130</td>
</tr>
<tr>
<td>Sample Size:</td>
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</tr>
<tr>
<td>Resp N:</td>
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<tr>
<td>Response:</td>
<td>7.7 %</td>
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<tr>
<td>Description of Sample:</td>
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<table>
<thead>
<tr>
<th>Low</th>
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<tbody>
<tr>
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<td>0.00</td>
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<tr>
<td>Pre-Service Evaluation Time:</td>
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<td></td>
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<td>Pre-Service Positioning Time:</td>
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<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Intra-Service Time:</td>
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<td>100.00</td>
<td>120.00</td>
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</table>

| Immediate Post Service-Time: | 20.00 |

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
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<td>Other Hospital time/visit(s):</td>
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<td>Discharge Day Mgmt:</td>
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<td>Office time/visit(s):</td>
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<tr>
<td>Prolonged Services:</td>
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</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Physician standard total minutes per E/M visit:** 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>27130</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Physician Work RVU:</td>
<td>19.60</td>
</tr>
</tbody>
</table>

| 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)

| Immediate Post Service-Time: | 20.00 | 33.00 | -13.00 |
**Post-Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99292x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99231x 0.00</td>
<td>80.00</td>
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<tr>
<td>99232x 2.00</td>
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<tr>
<td>99238x 1.0</td>
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<td>99239x 0.00</td>
<td>99241x</td>
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<tr>
<td>99242x 0.00</td>
<td>99243x 0.00</td>
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<td>99244x 0.00</td>
<td>99245x 0.00</td>
</tr>
<tr>
<td>99246x 0.00</td>
<td>99247x 0.00</td>
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</table>

**Critical Care time/visit(s):**

Critical Care time/visit(s):

- Critical Care time/visit(s): 0.00

**Other Hospital time/visit(s):**

Other Hospital time/visit(s):

- Other Hospital time/visit(s): 80.00

**Discharge Day Mgmt:**

Discharge Day Mgmt:

- Discharge Day Mgmt: 38.00

**Office time/visit(s):**

Office time/visit(s):

- Office time/visit(s): 69.00

**Prolonged Services:**

Prolonged Services:

- Prolonged Services: 0.00

**Sub Obs Care:**

Sub Obs Care:

- Sub Obs Care: 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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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</thead>
<tbody>
<tr>
<td>23472</td>
<td>090</td>
<td>22.13</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**CPT Descriptor** Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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<tbody>
<tr>
<td>22551</td>
<td>090</td>
<td>25.00</td>
<td>RUC Time</td>
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</table>

**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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>090</td>
<td>17.75</td>
<td>RUC Time</td>
<td>8,490</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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</thead>
<tbody>
<tr>
<td>090</td>
<td>33.75</td>
<td>RUC Time</td>
<td>60,369</td>
</tr>
</tbody>
</table>

**CPT Descriptor 2** Coronary artery bypass, using arterial graft(s); single arterial graft.

**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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 27130</th>
<th>Top Key Reference CPT Code: 23472</th>
<th>2nd Key Reference CPT Code: 22551</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>75.00</td>
<td>98.00</td>
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<tr>
<td>Median Intra-Service Time</td>
<td>100.00</td>
<td>140.00</td>
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<tr>
<td>Median Immediate Post-service Time</td>
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<td>30.00</td>
<td>30.00</td>
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<td>Median Critical Care Time</td>
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<td>Median Other Hospital Visit Time</td>
<td>80.00</td>
<td>80.00</td>
<td>40.00</td>
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<tr>
<td>Median Discharge Day Management Time</td>
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<td>38.00</td>
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<tr>
<td>Median Office Visit Time</td>
<td>69.00</td>
<td>85.00</td>
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<tr>
<td>Prolonged Services Time</td>
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<tr>
<td>Median Subsequent Observation Care Time</td>
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<tr>
<td>Median Total Time</td>
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<td>395.00</td>
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<tr>
<td>Other time if appropriate</td>
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</table>

### 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

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>4%</td>
<td>32%</td>
<td>54%</td>
<td>10%</td>
</tr>
</tbody>
</table>

#### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>53%</td>
<td>41%</td>
</tr>
</tbody>
</table>

#### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>8%</td>
<td>50%</td>
<td>42%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>1%</td>
<td>25%</td>
<td>74%</td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>52%</td>
<td>46%</td>
</tr>
</tbody>
</table>
- 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

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td>Less</td>
<td>Identical</td>
<td>More</td>
<td>More</td>
</tr>
</tbody>
</table>

| Overall intensity/complexity | 0% | 3% | 41% | 39% | 17% |

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>6%</td>
<td>47%</td>
<td>47%</td>
</tr>
</tbody>
</table>
- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

| Physical effort required | 0% | 19% | 81% |

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>64%</td>
<td>31%</td>
</tr>
</tbody>
</table>
- 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

**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

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMED POST</th>
<th>POST-OP HOSPITAL VISITS</th>
<th>POST-OP OFFICE VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>19.60</td>
<td>0.108</td>
<td>377</td>
<td>70</td>
<td>100</td>
<td>20</td>
<td>2-99232</td>
<td>1-99238</td>
</tr>
<tr>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))</td>
<td>22.13</td>
<td>0.089</td>
<td>448</td>
<td>75</td>
<td>140</td>
<td>30</td>
<td>1-99232</td>
<td>2-99231</td>
</tr>
<tr>
<td>22851</td>
<td>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophysectomy and decompression of spinal cord and/or nerve roots; cervical below C2</td>
<td>25.00</td>
<td>0.140</td>
<td>395</td>
<td>98</td>
<td>120</td>
<td>30</td>
<td>1-99232</td>
<td>1-99238</td>
</tr>
</tbody>
</table>

### MPC Comparison

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPUT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMED POST</th>
<th>POST-OP HOSPITAL VISITS</th>
<th>POST-OP OFFICE VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>37215</td>
<td>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</td>
<td>17.75</td>
<td>0.106</td>
<td>337</td>
<td>80</td>
<td>103</td>
<td>30</td>
<td>1-99232</td>
<td>1-99238</td>
</tr>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>19.60</td>
<td>0.108</td>
<td>377</td>
<td>70</td>
<td>100</td>
<td>20</td>
<td>2-99232</td>
<td>1-99238</td>
</tr>
<tr>
<td>33533</td>
<td>Coronary artery bypass, using arterial graft(s); single arterial graft</td>
<td>33.75</td>
<td>0.096</td>
<td>682</td>
<td>95</td>
<td>158</td>
<td>40</td>
<td>1-99291</td>
<td>1-99233</td>
</tr>
</tbody>
</table>

### ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK


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 in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty surgery</td>
<td>Commonly</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty orthopaedic surgery</td>
<td>162000</td>
<td>99.99 %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
</tbody>
</table>

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.
CPT Code: 27447

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27447  Tracking Number  Original Specialty Recommended RVU: 20.72
Global Period: 090  Current Work RVU: 20.72  Presented Recommended RVU: 19.60

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 evertting 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  
**CPT Code:** 27447  
**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)  

### Sample Size
- **Sample Size:** 2650  
- **Resp N:** 206  
- **Response:** 7.7%

### Description of Sample
- random

<table>
<thead>
<tr>
<th>Service Performance Rate</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey RVW</td>
<td>17.00</td>
<td>22.14</td>
<td>24.00</td>
<td>25.00</td>
<td>32.50</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td></td>
<td>40.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Intra-Service Time: | 45.00 | 86.00 | 97.00 | 120.00 | 185.00 |

| Immediate Post Service-Time: | 20.00 |

### Post Operative 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**

| 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 |

### 9B General Anes or Complex Regional Blk/Cmplx Proc

| Immediate Post Service-Time: | 20.00 | 33.00 | -13.00 |
CPT Code: 27447

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>80.00</td>
<td>99231x 0.00 99232x 2.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>38.00</td>
<td>99238x 1.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>69.00</td>
<td>99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>23472</td>
<td>090</td>
<td>22.13</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

SECOND HIGHEST KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>22551</td>
<td>090</td>
<td>25.00</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>37215</td>
<td>090</td>
<td>17.75</td>
<td>RUC Time</td>
<td>8,490</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>33533</td>
<td>090</td>
<td>33.75</td>
<td>RUC Time</td>
<td>60,369</td>
</tr>
</tbody>
</table>

CPT Descriptor 2 Coronary artery bypass, using arterial graft(s); single arterial graft

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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 27447</th>
<th>Top Key Reference CPT Code: 23472</th>
<th>2nd Key Reference CPT Code: 22551</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>70.00</td>
<td>75.00</td>
<td>98.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>97.00</td>
<td>140.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>20.00</td>
<td>30.00</td>
<td>30.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>80.00</td>
<td>80.00</td>
<td>40.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>38.00</td>
<td>38.00</td>
<td>38.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>69.00</td>
<td>85.00</td>
<td>69.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>374.00</td>
<td>448.00</td>
<td>395.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>6%</td>
<td>34%</td>
<td>48%</td>
<td>12%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>58%</td>
<td>38%</td>
</tr>
</tbody>
</table>

* 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>47%</td>
<td>43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>36%</td>
<td>63%</td>
<td></td>
</tr>
</tbody>
</table>
### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>55%</td>
<td>42%</td>
</tr>
</tbody>
</table>
- 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

### 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>Less</td>
<td>Less</td>
<td>3%</td>
<td>38%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>
- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>3%</td>
<td>44%</td>
<td>53%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>3%</td>
<td>28%</td>
<td>69%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>72%</td>
<td>22%</td>
</tr>
</tbody>
</table>
- 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

### 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

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPOT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMEDIATE POST</th>
<th>POST-OP HOSPITAL VISITS</th>
<th>POST-OP OFFICE VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>19.60</td>
<td>0.112</td>
<td>374</td>
<td>70</td>
<td>97</td>
<td>20</td>
<td>2-99232</td>
<td>3-99213</td>
</tr>
<tr>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))</td>
<td>22.13</td>
<td>0.089</td>
<td>448</td>
<td>75</td>
<td>140</td>
<td>30</td>
<td>1-99232</td>
<td>3-99213</td>
</tr>
<tr>
<td>22851</td>
<td>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyectomy and decompression of spinal cord and/or nerve roots; cervical below C2</td>
<td>25.00</td>
<td>0.140</td>
<td>395</td>
<td>98</td>
<td>120</td>
<td>30</td>
<td>1-99232</td>
<td>3-99213</td>
</tr>
</tbody>
</table>

### MPC Comparison

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>RVW</th>
<th>IWPOT</th>
<th>TOTAL TIME</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMEDIATE POST</th>
<th>POST-OP HOSPITAL VISITS</th>
<th>POST-OP OFFICE VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>37215</td>
<td>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</td>
<td>17.75</td>
<td>0.106</td>
<td>337</td>
<td>80</td>
<td>103</td>
<td>30</td>
<td>1-99232</td>
<td>2-99213</td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
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<td>374</td>
<td>70</td>
<td>97</td>
<td>20</td>
<td>2-99232</td>
<td>3-99213</td>
</tr>
<tr>
<td>33533</td>
<td>Coronary artery bypass, using arterial graft(s); single arterial graft</td>
<td>33.75</td>
<td>0.096</td>
<td>682</td>
<td>95</td>
<td>158</td>
<td>40</td>
<td>1-99214</td>
<td>1-99212</td>
</tr>
</tbody>
</table>

### ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK


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 in your specialty 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?
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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic surgery</td>
<td>306000</td>
<td>99.90 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic surgery</td>
<td>306000</td>
<td>99.90 %</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>CPT</th>
<th>DESC</th>
<th>Resp</th>
<th>IWPUT</th>
<th>MIN</th>
<th>25th</th>
<th>MED</th>
<th>75th</th>
<th>MAX</th>
<th>Time</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>POST-OFFICE</th>
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</thead>
<tbody>
<tr>
<td>REF1</td>
<td>23472</td>
<td>Arthroplasty, glenohumeral joint</td>
<td>103</td>
<td>0.089</td>
<td>22.13</td>
<td>448</td>
<td>40</td>
<td>15</td>
<td>20</td>
<td>140</td>
<td>30</td>
<td>2</td>
<td>1.0</td>
<td>3</td>
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<td>22551</td>
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<td>120</td>
<td>30</td>
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<td>3</td>
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<tr>
<td>2013 RUC</td>
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<td>Arthroplasty, acetabular and proximal</td>
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<td>19.60</td>
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<td>20</td>
<td>100</td>
<td>25</td>
<td>1</td>
<td>1.0</td>
<td>2</td>
</tr>
<tr>
<td>current</td>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal</td>
<td>0.110</td>
<td>20.72</td>
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<td>40</td>
<td>15</td>
<td>20</td>
<td>100</td>
<td>25</td>
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<td>1.0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>SVY</td>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal</td>
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<td>0.152</td>
<td>18.50</td>
<td>22.50</td>
<td>24.00</td>
<td>25.00</td>
<td>40.00</td>
<td>377</td>
<td>40</td>
<td>15</td>
<td>15</td>
<td>45</td>
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<tr>
<td>REC</td>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal</td>
<td>0.108</td>
<td>19.60</td>
<td>377</td>
<td>40</td>
<td>15</td>
<td>15</td>
<td>100</td>
<td>20</td>
<td>2</td>
<td>1.0</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
FACILITY DIRECT PE INPUTS
CPT CODE(S): 27130, 27447

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION

Meeting Date: 10/2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip</td>
<td>090</td>
</tr>
<tr>
<td></td>
<td>arthroplasty), with or without autograft or allograft</td>
<td></td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with</td>
<td>090</td>
</tr>
<tr>
<td></td>
<td>or without patella resurfacing (total knee arthroplasty)</td>
<td></td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>A 72-year-old female has hip osteoarthritis not responding to non-operative treatment. A total hip arthroplasty (THA) is performed.</td>
</tr>
<tr>
<td>27447</td>
<td>A 74-year-old female has knee osteoarthritis not responding to non-operative treatment. A total knee arthroplasty (TKA) is performed.</td>
</tr>
</tbody>
</table>

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:
AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION

- 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 (e.g., NPO, medications, antibiotic shower).

TOTAL Pre-operative CLINICAL STAFF TIME (minutes)

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>27130</td>
</tr>
</tbody>
</table>

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 (e.g., 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
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

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESC</th>
<th>MIN</th>
<th>25TH %</th>
<th>MEDIAN</th>
<th>75TH%</th>
<th>MAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>27130</td>
<td>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft</td>
<td>0</td>
<td>60</td>
<td>90</td>
<td>120</td>
<td>360</td>
</tr>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>0</td>
<td>60</td>
<td>90</td>
<td>120</td>
<td>360</td>
</tr>
</tbody>
</table>

**Histogram**

- Mean = 99.72
- Std. Dev. = 64.917
- N = 206
ARTICLES SUPPORTING ADDITIONAL PREOPERATIVE PATIENT OPTIMIZATION WORK


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:

<table>
<thead>
<tr>
<th>Description</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete pre-service diagnostic and referral forms</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>
### AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
### PRACTICE EXPENSE SUMMARY OF RECOMMENDATION

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Time Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff reviews all forms with patient and/or caregiver to ensure all relevant history and diagnostic information is included</td>
<td></td>
</tr>
<tr>
<td>Coordinate pre-surgery services (including test results)</td>
<td>30 minutes (20 min standard plus 10 add'l min)</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Schedule space and equipment in facility</td>
<td>8 minutes (standard)</td>
</tr>
<tr>
<td>Staff interacts with facility to schedule space, supplies, equipment, and review checklists</td>
<td></td>
</tr>
<tr>
<td>Provide pre-service education/obtain consent</td>
<td>40 minutes (20 min standard plus 20 add'l min)</td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Complete pre-procedure phone calls and prescription</td>
<td>7 minutes (standard)</td>
</tr>
<tr>
<td>Staff reviews preoperative medication changes, reviews patient medical status, confirms preoperative cleansing protocol, and answers final pre-admission questions.</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 current (2019) office visit E/Ms**

Clinical staff will greet the patient, provide gowing, 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
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 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).
<table>
<thead>
<tr>
<th>Clinical Activity Code</th>
<th>Clinical Staff Type Code</th>
<th>Clinical Staff Type</th>
<th>Clinical Staff Type Rate Per Minute</th>
<th>Total Hip Arthroplasty, acetabular and proximal femoral</th>
<th>Total Hip Arthroplasty, acetabular and proximal femoral</th>
<th>Total Knee Arthroplasty, knee, condylar and plateau, medial AND lateral</th>
<th>Total Knee Arthroplasty, knee, condylar and plateau, medial AND lateral</th>
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</thead>
<tbody>
<tr>
<td>L037D</td>
<td>RN/LPN/MTA</td>
<td>0.37</td>
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<td>0</td>
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<td>60</td>
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<tr>
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<td>0</td>
<td>12</td>
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<td>12</td>
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</tr>
<tr>
<td>L037D</td>
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<td>0.37</td>
<td>0</td>
<td>108</td>
<td>0</td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>L037D</td>
<td>RN/LPN/MTA</td>
<td>0.37</td>
<td>0</td>
<td>60</td>
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<tr>
<td>L037D</td>
<td>RN/LPN/MTA</td>
<td>0.37</td>
<td>0</td>
<td>12</td>
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<tr>
<td>L037D</td>
<td>RN/LPN/MTA</td>
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<td>0</td>
<td>108</td>
<td>0</td>
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</tbody>
</table>

**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**

<table>
<thead>
<tr>
<th></th>
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<th>Facility</th>
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<th>Facility</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$ -</td>
<td>$ 76.60</td>
<td>$ -</td>
<td>$ 76.60</td>
<td>$ -</td>
<td>$ 76.60</td>
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<td>$ 76.60</td>
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**TABLE OF MEDICAL SUPPLIES**

<table>
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<tr>
<th>Supply Code</th>
<th>MEDICAL SUPPLIES</th>
<th>PRICE</th>
<th>UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA048</td>
<td>pack, minimum multi-specialty visit</td>
<td>2.1122</td>
<td>pack</td>
</tr>
<tr>
<td>SA052</td>
<td>pack, post-op incision care (staple)</td>
<td>4.982</td>
<td>pack</td>
</tr>
</tbody>
</table>

**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**

<table>
<thead>
<tr>
<th></th>
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<th>Facility</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$ -</td>
<td>$ 1.75</td>
<td>$ -</td>
<td>$ 1.75</td>
</tr>
</tbody>
</table>

**Location:**
- **Non Fac:**
- **Facility:**

**Total Cost of Clinical Activity Time, Supplies and Equipment Time:**

- **Non Fac:** $79.67
- **Facility:** $79.67
- **Non Fac:** $79.67
- **Facility:** $79.67
- **Non Fac:** $79.67
- **Facility:** $79.67
- **Non Fac:** $79.67
- **Facility:** $79.67

**Clinical Staff Type Code:**
- **RN/LPN/MTA:**

**Clinical Staff Type Rate Per Minute:**
- **0.37:**

**Global Period:**

- **n/a:**
- **90:**

**Total Pre-Service Clinical Staff Time:**

- **0.37:**
- **L037D:**

**Pre-Service Period:**

- **Start:** Following visit when decision for surgery/procedure made
- **End:** When patient enters office/facility for surgery/procedure

**Total Service Period Clinical Staff Time:**

- **0.37:**
- **L037D:**

**Service Period:**

- **Start:** When patient enters office/facility for surgery/procedure:
- **End:** Patient leaves office/facility

**Post-Service Period:**

- **Start:** Patient leaves office/facility
- **End:** with last office visit before end of global period

**Total Cost of Clinical Staff Time x Rate per Minute:**

<table>
<thead>
<tr>
<th></th>
<th>Non Fac</th>
<th>Facility</th>
<th>Non Fac</th>
<th>Facility</th>
<th>Non Fac</th>
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<th>Non Fac</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$ -</td>
<td>$ 66.60</td>
<td>$ -</td>
<td>$ 66.60</td>
<td>$ -</td>
<td>$ 66.60</td>
<td>$ -</td>
<td>$ 66.60</td>
</tr>
</tbody>
</table>

**Clinical Staff Type:**

- **AAOS, AAHKS**
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 25\(^{th}\) 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*

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\(^1\) [https://www.tandfonline.com/doi/full/10.4161/hv.25085](https://www.tandfonline.com/doi/full/10.4161/hv.25085)

\(^2\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242184/](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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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

<table>
<thead>
<tr>
<th>CPT</th>
<th>Specialty</th>
<th>Responses</th>
<th>Response %</th>
<th>Median Time</th>
<th>2019 Medicare Claims Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td>Pediatrics (AAP)</td>
<td>83</td>
<td>83%</td>
<td>3 min</td>
<td>0.5%</td>
</tr>
<tr>
<td></td>
<td>Internal Med (ACP)</td>
<td>6</td>
<td>6%</td>
<td>5 min</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioners (ANA)</td>
<td>6</td>
<td>6%</td>
<td>9 min</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Ob/Gyn (ACOG)</td>
<td>5</td>
<td>5%</td>
<td>9 min</td>
<td>0.3%</td>
</tr>
<tr>
<td></td>
<td>Family Medicine (AAFP)</td>
<td>0</td>
<td></td>
<td></td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*
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**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Specialty</th>
<th>Responses</th>
<th>Response %</th>
<th>Median Time</th>
<th>2019 Medicare Claims Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>90472</td>
<td>Pediatrics (AAP)</td>
<td>81</td>
<td>84%</td>
<td>3 min</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Internal Med (ACP)</td>
<td>6</td>
<td>6%</td>
<td>5 min</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioners (ANA)</td>
<td>5</td>
<td>5%</td>
<td>5 min</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Ob/Gyn (ACOG)</td>
<td>5</td>
<td>5%</td>
<td>8 min</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Family Medicine (AAFP)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>97</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
</table>
| 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>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</td>
<td>XXX 0.24</td>
</tr>
<tr>
<td>90461</td>
<td>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)</td>
<td>ZZZ 0.18</td>
</tr>
<tr>
<td></td>
<td>(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)</td>
<td></td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX 0.17</td>
</tr>
<tr>
<td></td>
<td>(Do not report 90471 in conjunction with 90473)</td>
<td>(No change)</td>
</tr>
<tr>
<td>90472</td>
<td>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)</td>
<td>ZZZ 0.15</td>
</tr>
<tr>
<td></td>
<td>(Use 90472 in conjunction with 90460, 90471, 90473)</td>
<td>(No change)</td>
</tr>
<tr>
<td></td>
<td>(For immune globulins, see 90281-90399. For administration of immune globulins, see 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96374)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(For intravesical administration of BCG vaccine, see 51720, 90586)</td>
<td></td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX 0.17</td>
</tr>
<tr>
<td></td>
<td>(Do not report 90473 in conjunction with 90471)</td>
<td>(No change)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Modifier</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>90474</td>
<td>Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>0.15</td>
<td>(No change)</td>
</tr>
<tr>
<td>G0008</td>
<td>Administration of influenza virus vaccine</td>
<td>XXX</td>
<td>0.17</td>
<td>(Value is linked to 90471)</td>
</tr>
<tr>
<td>G0009</td>
<td>Administration of pneumococcal vaccine</td>
<td>XXX</td>
<td>0.17</td>
<td>(Value is linked to 90471)</td>
</tr>
<tr>
<td>G0010</td>
<td>Administration of hepatitis b vaccine</td>
<td>XXX</td>
<td>0.17</td>
<td>(Value is linked to 90471)</td>
</tr>
</tbody>
</table>
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
CPT Code: 90460

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:
### CPT Code: 90460

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>325.00</td>
<td>1000.00</td>
<td>1788.00</td>
<td>30413.00</td>
</tr>
<tr>
<td>Survey RVW</td>
<td>0.15</td>
<td>0.24</td>
<td>0.27</td>
<td>0.60</td>
<td>1.30</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time</td>
<td>1.00</td>
<td>5.00</td>
<td>7.00</td>
<td>10.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care time/visit(s)</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s)</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s)</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

**CPT Code:** 90460  **Recommended Physician Work RVU:** 0.24

<table>
<thead>
<tr>
<th>Description</th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time</td>
<td>7.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

**Immediate Post Service-Time:** 0.00  **0.00  0.00**
CPT Code: 90460

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>XXX</td>
<td>0.24</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

**SECOND HIGHEST KEY REFERENCE SERVICE:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>XXX</td>
<td>0.70</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>74019</td>
<td>XXX</td>
<td>0.23</td>
<td>RUC Time</td>
<td>429,437</td>
</tr>
</tbody>
</table>

CPT Descriptor 1 Radiologic examination, abdomen; 2 views

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>93922</td>
<td>XXX</td>
<td>0.25</td>
<td>RUC Time</td>
<td>694,382</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 90460</th>
<th>Top Key Reference CPT Code: 99406</th>
<th>2nd Key Reference CPT Code: 99212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>7.00</td>
<td>7.00</td>
<td>11.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>7.00</td>
<td>7.00</td>
<td>16.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**  
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>4%</td>
<td>0%</td>
<td>12%</td>
<td>56%</td>
<td>28%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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  

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16%</td>
<td>32%</td>
<td>52%</td>
</tr>
</tbody>
</table>
## Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>4%</td>
<td>36%</td>
<td>60%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>8%</td>
<td>60%</td>
<td>32%</td>
</tr>
</tbody>
</table>

## Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>4%</td>
<td>20%</td>
<td>76%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th></th>
<th>Much</th>
<th>Somewhat</th>
<th>Identical</th>
<th>Somewhat</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>17%</td>
<td>33%</td>
<td>38%</td>
<td>12%</td>
</tr>
</tbody>
</table>

## Mental Effort and Judgment

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnoses and/or the number of management options that must be considered</td>
<td>21%</td>
<td>38%</td>
<td>42%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>8%</td>
<td>50%</td>
<td>42%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>13%</td>
<td>54%</td>
<td>33%</td>
</tr>
</tbody>
</table>

## Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>8%</td>
<td>38%</td>
<td>54%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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, 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>88311</td>
<td>Decalcification procedure</td>
<td>XXX</td>
<td>0.24</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>99406</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes</td>
<td>XXX</td>
<td>0.24</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>90460</td>
<td>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</td>
<td>XXX</td>
<td>0.24</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>77073</td>
<td>Bone length studies (orthoroentgenogram, scanogram)</td>
<td>XXX</td>
<td>0.26</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>92202</td>
<td>Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral</td>
<td>XXX</td>
<td>0.26</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>70260</td>
<td>Radiologic examination, skull; complete, minimum of 4 views</td>
<td>XXX</td>
<td>0.28</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213 XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>90460 XXX</td>
<td>0.24</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1.54</td>
<td>5</td>
<td>27</td>
<td>5</td>
</tr>
</tbody>
</table>

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

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.
CPT Code: 90461

Tracking Number

Original Specialty Recommended RVU: 0.18
Presented Recommended RVU: 0.18
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:
### 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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>217.00</td>
<td>560.00</td>
<td>1506.00</td>
<td>27775.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.10</td>
<td>0.18</td>
<td>0.24</td>
<td>0.40</td>
<td>1.30</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>1.00</td>
<td>3.00</td>
<td>5.00</td>
<td>7.00</td>
<td>18.00</td>
</tr>
<tr>
<td><strong>Immediate Post Service-Time:</strong></td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**

<table>
<thead>
<tr>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care/visit(s):</td>
<td>0.00 99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other hospital/visit(s):</td>
<td>0.00 99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00 99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00 99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00 99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00 99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th></th>
<th>Specialties</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 0.00 0.00 0.00

**Specialty Society Recommended Pre-Service Time**

<table>
<thead>
<tr>
<th></th>
<th>Specialties</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>5.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
</tbody>
</table>

**Recommended Physician Work RVU:** 0.18

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 for any category)

<table>
<thead>
<tr>
<th></th>
<th>Specialties</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediate Post Service-Time:</strong></td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>
CPT Code: 90461

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>ZZZ</td>
<td>0.10</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96411</td>
<td>ZZZ</td>
<td>0.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>93010</td>
<td>XXX</td>
<td>0.17</td>
<td>RUC Time</td>
<td>18,866,949</td>
</tr>
</tbody>
</table>

CPT Descriptor: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>96367</td>
<td>ZZZ</td>
<td>0.19</td>
<td>RUC Time</td>
<td>1,292,846</td>
</tr>
</tbody>
</table>

CPT Descriptor: 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)

**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Other Reference CPT Code
Global | Work RVU | Time Source
0.00

CPT Descriptor
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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 90461</th>
<th>Top Key Reference CPT Code: 96375</th>
<th>2nd Key Reference CPT Code: 96411</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>5.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td><strong>5.00</strong></td>
<td><strong>4.00</strong></td>
<td><strong>7.00</strong></td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>4%</td>
<td>9%</td>
<td>39%</td>
<td>30%</td>
<td>17%</td>
</tr>
</tbody>
</table>

#### Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>22%</td>
<td>65%</td>
<td>13%</td>
</tr>
</tbody>
</table>
### Physical effort required

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>17%</td>
<td>52%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>30%</td>
<td>57%</td>
</tr>
</tbody>
</table>

- 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

### Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>18%</td>
<td>41%</td>
<td>36%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>32%</td>
<td>41%</td>
<td>27%</td>
</tr>
</tbody>
</table>

- 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

### Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>23%</td>
<td>59%</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>32%</td>
<td>55%</td>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>

### Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>36%</td>
<td>27%</td>
<td>36%</td>
</tr>
</tbody>
</table>

- 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

### 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.

*Additional rationale and comments*
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, 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug</td>
<td>ZZZ</td>
<td>0.10</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>96366</td>
<td>Intravenous infusion, for therapy, prophylaxis,</td>
<td>ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Value</td>
<td>Value</td>
<td>Value</td>
<td>Value</td>
<td>Value</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>90461</td>
<td>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</td>
<td>ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>96370</td>
<td>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour</td>
<td>ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>96415</td>
<td>Chemotherapy administration, intravenous infusion technique; each additional hour</td>
<td>ZZZ</td>
<td>0.19</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

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.)

- [x] 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.
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213 XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>90460 XXX</td>
<td>0.24</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>90461 ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1.72</td>
<td>5</td>
<td>32</td>
<td>5</td>
</tr>
</tbody>
</table>

**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

**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:
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.
CPT Code: 90471  Tracking Number

Global Period: XXX  Current Work RVU: 0.17

CPT Code: 90471

Original Specialty Recommended RVU: 0.17
Presented Recommended 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>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</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>90471</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>12828</td>
</tr>
<tr>
<td>Resp N:</td>
<td>100</td>
</tr>
</tbody>
</table>

### Description of Sample:
Random

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>50.00</td>
<td>216.00</td>
<td>500.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.10</td>
<td>0.18</td>
<td>0.20</td>
<td>0.30</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>2.00</td>
<td>4.00</td>
<td>7.00</td>
</tr>
</tbody>
</table>

### Immediate Post Service-Time:
0.00

### Post Operative 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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>90471</th>
<th>Recommended Physician Work RVU: 0.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>7.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

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)

**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)
CPT Code: 90471

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>XXX</td>
<td>0.18</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99188</td>
<td>XXX</td>
<td>0.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>73120</td>
<td>XXX</td>
<td>0.16</td>
<td>RUC Time</td>
<td>278,753</td>
</tr>
</tbody>
</table>

CPT Descriptor Radiologic examination, hand; 2 views

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>XXX</td>
<td>0.18</td>
<td>RUC Time</td>
<td>2,684,197</td>
</tr>
</tbody>
</table>

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.

Other Reference CPT Code | Global | Work RVU | Time Source |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 90471</th>
<th>Top Key Reference CPT Code: 99211</th>
<th>2nd Key Reference CPT Code: 99188</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>99188.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>7.00</td>
<td>7.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>7.00</td>
<td>7.00</td>
<td>9.00</td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**  
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>8%</td>
<td>53%</td>
<td>37%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>74%</td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>63%</td>
<td>26%</td>
<td></td>
</tr>
</tbody>
</table>
CPT Code: 90471

Physical effort required
8% 68% 24%

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>32%</td>
<td>58%</td>
</tr>
</tbody>
</table>

- 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

Survey Code Compared to 2nd Key Reference Code

<table>
<thead>
<tr>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>48%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Overall intensity/complexity

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>19%</td>
<td>71%</td>
</tr>
</tbody>
</table>

- 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

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>24%</td>
<td>52%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Technical skill required

<table>
<thead>
<tr>
<th>Physical effort required</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
</tr>
</tbody>
</table>

Psychological Stress

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>0%</td>
<td>95%</td>
</tr>
</tbody>
</table>

- 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

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>94781</td>
<td>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</td>
<td>ZZZ</td>
<td>0.17</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX</td>
<td>0.17</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>90970</td>
<td>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</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>3.2</td>
<td>0</td>
<td>3.2</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>
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.

Application of topical fluoride varnish by a physician or other qualified health care professional

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td></td>
<td>0.17</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>99188</td>
<td></td>
<td>0.20</td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1.47</td>
<td>5</td>
<td>24</td>
<td>5</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>90471</td>
<td>XXX</td>
<td>0.17</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1.47</td>
<td>5</td>
<td>24</td>
<td>5</td>
</tr>
</tbody>
</table>

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.
CPT Code: 90471

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
<th>Commonly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty Medicine</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>39832832</td>
<td>24.56 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>35557273</td>
<td>21.92 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty Medicine</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>99672</td>
<td>35.29 %</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>73130</td>
<td>25.89 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>47718</td>
<td>16.89 %</td>
</tr>
</tbody>
</table>

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:
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.
CPT Code: 90472

Tracking Number                    Original Specialty Recommended RVU: **0.15**
Global Period: ZZZ                    Presented Recommended RVU: **0.15**
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>90472</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>12828</td>
</tr>
<tr>
<td><strong>Resp N:</strong></td>
<td>97</td>
</tr>
</tbody>
</table>

**Description of Sample:** Random

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>5.00</td>
<td>25.00</td>
<td>100.00</td>
<td>6496.00</td>
</tr>
</tbody>
</table>

**Service Performance Rate**

**Survey RVW:**

- 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**

| 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 | 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 |

**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)

**Recommended Physician Work RVU:** 0.15

**CPT Code:** 90472

| 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)

**Immediate Post Service Time:** 0.00 0.00 0.00
### Post-Operative Visits

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291x 0.00 99292x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### 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? Yes

### TOP KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>ZZZ</td>
<td>0.10</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96411</td>
<td>ZZZ</td>
<td>0.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>ZZZ</td>
<td>0.10</td>
<td>RUC Time</td>
<td>1,416,745</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>73120</td>
<td>XXX</td>
<td>0.16</td>
<td>RUC Time</td>
<td>278,753</td>
</tr>
</tbody>
</table>

**CPT Descriptor 2**: Radiologic examination, hand; 2 views

### 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)

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 90472</th>
<th>Top Key Reference CPT Code: 96375</th>
<th>2nd Key Reference CPT Code: 96411</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>7.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>7.00</td>
<td>4.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTENSITY/COMPLEXITY MEASURES  
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall intensity/complexity</strong></td>
<td>8%</td>
<td>10%</td>
<td>50%</td>
<td>28%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>20%</td>
<td>70%</td>
<td>10%</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug</td>
<td>ZZZ</td>
<td>0.10</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>73020</td>
<td>Radiologic examination, shoulder; 1 view</td>
<td>XXX</td>
<td>0.15</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>78730</td>
<td>Urinary bladder residual study</td>
<td>ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>90472</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid)</td>
<td>ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>90970</td>
<td>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</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>3.2</td>
<td>0</td>
<td>3.2</td>
</tr>
<tr>
<td>96370</td>
<td>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour</td>
<td>ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>96411</td>
<td>Chemotherapy administration;</td>
<td>ZZZ</td>
<td>0.20</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>
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 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213 XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>90471 XXX</td>
<td>0.17</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>90472 ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1.62</td>
<td>5</td>
<td>27</td>
<td>5</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>9531944</td>
<td>39.19 %</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>4421664</td>
<td>18.17 %</td>
</tr>
</tbody>
</table>
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

**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.
CPT Code: 90473

Tracking Number
Original Specialty Recommended RVU: 0.17
Presented Recommended 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

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>13.00</td>
<td>113.00</td>
<td>2000.00</td>
</tr>
<tr>
<td>Survey RVW</td>
<td>0.10</td>
<td>0.18</td>
<td>0.20</td>
<td>0.27</td>
<td>1.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time</td>
<td>0.00</td>
<td>2.00</td>
<td>3.00</td>
<td>6.00</td>
<td>12.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th></th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Post Service-Time</td>
<td></td>
</tr>
</tbody>
</table>

####Post Operative Visits:

<table>
<thead>
<tr>
<th>Critical care time/visit(s):</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Min**</td>
<td></td>
</tr>
<tr>
<td>CPT Code and Number of Visits</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Hospital time/visit(s):</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Day Mgmt:</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office time/visit(s):</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prolonged Services:</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub Obs Care:</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>90473</th>
<th>Recommended Physician Work RVU: 0.17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specialty Recommended Pre-Service Time</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>7.00</td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Immediate Post Service-Time:</th>
<th>0.00</th>
<th>0.00</th>
<th>0.00</th>
</tr>
</thead>
</table>
**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>XXX</td>
<td>0.18</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>99188</td>
<td>XXX</td>
<td>0.20</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>73120</td>
<td>XXX</td>
<td>0.16</td>
<td>RUC Time</td>
<td>278,753</td>
</tr>
</tbody>
</table>

CPT Descriptor: Radiologic examination, hand; 2 views

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>XXX</td>
<td>0.18</td>
<td>RUC Time</td>
<td>2,684,197</td>
</tr>
</tbody>
</table>

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.

**Other Reference CPT Code**

<table>
<thead>
<tr>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th>CPT Code: 90473</th>
<th>Top Key Reference CPT Code: 99211</th>
<th>2nd Key Reference CPT Code: 99188</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>7.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>7.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

*(of those that selected Key Reference codes)*

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>3%</td>
<td>8%</td>
<td>50%</td>
<td>36%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

Less | Identical | More
---|-----------|---
19% | 58% | 22%

- 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

**Technical Skill/Physical Effort**

Less | Identical | More
---|-----------|---
6% | 61% | 33%
<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>8%</th>
<th>61%</th>
<th>31%</th>
</tr>
</thead>
</table>

**Psychological Stress**  
<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>36%</td>
<td>61%</td>
</tr>
</tbody>
</table>

- 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

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>5%</td>
<td>25%</td>
<td>50%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>25%</td>
<td>70%</td>
</tr>
</tbody>
</table>

- The number of possible diagnoses 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>45%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>40%</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>5%</td>
<td>95%</td>
</tr>
</tbody>
</table>

- 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

**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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>94781</td>
<td>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</td>
<td>ZZZ</td>
<td>0.17</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX</td>
<td>0.17</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>90970</td>
<td>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</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>3.2</td>
<td>0</td>
<td>3.2</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>
presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99188</td>
<td>Application of topical fluoride varnish by a physician or other qualified health care professional</td>
<td>XXX</td>
<td>0.20</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>90473</td>
<td>XXX</td>
<td>0.17</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1.47</td>
<td>5</td>
<td>23</td>
</tr>
</tbody>
</table>

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 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: Rarely

Specialty Internal Medicine: 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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Pediatrics</td>
<td>139661</td>
<td>69.20 %</td>
</tr>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>27851</td>
<td>13.79 %</td>
</tr>
<tr>
<td>Specialty Family Medicine</td>
<td>17962</td>
<td>8.89 %</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
CPT Code: 90474

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
RUC Recommended RVU: 0.15

Global Period: ZZZ  Current Work 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

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>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</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Nurses Association</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>90474</td>
</tr>
<tr>
<td>Sample Size:</td>
<td>12828</td>
</tr>
<tr>
<td>Resp N:</td>
<td>80</td>
</tr>
</tbody>
</table>

#### Description of Sample:
Random

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>17.00</td>
<td>1500.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.08</td>
<td>0.15</td>
<td>0.18</td>
<td>0.23</td>
<td>1.00</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>0.00</td>
<td>2.00</td>
<td>3.00</td>
<td>5.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Immediate Post Service-Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Operative Visits**: **Total Min**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care time/visit(s):</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
</tr>
<tr>
<td>Prolonged Services:</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>ZZ Global Code</th>
</tr>
</thead>
</table>

**Specialty Recommended Data**

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)

| ZZ Global Code |

---

**CPT Code**: 90474

**Recommended Physician Work RVU**: 0.15

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Pre-Service Time</th>
<th>Specialty Recommended Pre Time Package</th>
<th>Adjustments/Recommended Pre-Service Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>7.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

| ZZ Global Code |

---

**CPT Code**: 90474

**Recommended Physician Work RVU**: 0.15

<table>
<thead>
<tr>
<th></th>
<th>Specialty Recommended Post-Service Time</th>
<th>Specialty Recommended Post Time Package</th>
<th>Adjustments/Recommended Post-Service Time</th>
</tr>
</thead>
</table>

---

**CPT Code**: 90474

**Recommended Physician Work RVU**: 0.15
CPT Code: 90474

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>ZZZ</td>
<td>0.10</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

*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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>96370</td>
<td>ZZZ</td>
<td>0.18</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>ZZZ</td>
<td>0.10</td>
<td>RUC Time</td>
<td>1,416,745</td>
</tr>
</tbody>
</table>

*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)

<table>
<thead>
<tr>
<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>73120</td>
<td>XXX</td>
<td>0.16</td>
<td>RUC Time</td>
<td>278,753</td>
</tr>
</tbody>
</table>

*CPT Descriptor 2* Radiologic examination, hand; 2 views
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)**

<table>
<thead>
<tr>
<th></th>
<th>CPT Code: 90474</th>
<th>Top Key Reference CPT Code: 96375</th>
<th>2nd Key Reference CPT Code: 96370</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>7.00</td>
<td>4.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>7.00</td>
<td>4.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Other time if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTENSITY/COMPLEXITY MEASURES**

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>3%</td>
<td>15%</td>
<td>55%</td>
<td>21%</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

- 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
<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>27%</td>
<td>67%</td>
<td>6%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>18%</td>
<td>64%</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>15%</td>
<td>52%</td>
<td>33%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Code Compared to 2nd Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>14%</td>
<td>64%</td>
<td>21%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>29%</td>
<td>57%</td>
<td>14%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
</tr>
<tr>
<td>Physical effort required</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>20%</td>
<td>57%</td>
<td>21%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 25\textsuperscript{th} 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global</th>
<th>Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>96375</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug</td>
<td>ZZZ</td>
<td>0.10</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>73020</td>
<td>Radiologic examination, shoulder; 1 view</td>
<td>XXX</td>
<td>0.15</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>78730</td>
<td>Urinary bladder residual study</td>
<td>ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>90474</td>
<td>Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)</td>
<td>ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>90970</td>
<td>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</td>
<td>XXX</td>
<td>0.18</td>
<td>0</td>
<td>3.2</td>
<td>0</td>
<td>3.2</td>
</tr>
<tr>
<td>96370</td>
<td>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each</td>
<td>ZZZ</td>
<td>0.18</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
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 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Work RVU</th>
<th>Pre-Time</th>
<th>Intra-Time</th>
<th>Post-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213 XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>90473 XXX</td>
<td>0.17</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>90472 ZZZ</td>
<td>0.15</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1.62</td>
<td>5</td>
<td>26</td>
<td>5</td>
</tr>
</tbody>
</table>

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 %
CPT Code: 90474

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.)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Nurse Practitioner</td>
<td>138476</td>
<td>13.79 %</td>
</tr>
<tr>
<td>Specialty Family Medicine</td>
<td>89307</td>
<td>8.89 %</td>
</tr>
</tbody>
</table>

Do many physicians perform this service across the United States?

**Berson-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.
### Immunization Administration

#### Data Table

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>Year</th>
<th>Resp</th>
<th>Work Per Unit Time</th>
<th>RVW</th>
<th>Total Time</th>
<th>PRE-TIME</th>
<th>INTRA-TIME</th>
<th>IMMO</th>
<th>POST</th>
<th>SURVEY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>99406</td>
<td>XXX</td>
<td>Smoking and tobacco use cessation counseling visit;</td>
<td>2007</td>
<td>25</td>
<td>0.034</td>
<td>0.24</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>99212</td>
<td>XXX</td>
<td>Office or outpatient visit for the evaluation and</td>
<td>2019</td>
<td>24</td>
<td>0.053</td>
<td>0.70</td>
<td>16</td>
<td>2</td>
<td>11</td>
<td>3</td>
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<td></td>
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<tr>
<td>CURRENT</td>
<td>90460</td>
<td>XXX</td>
<td>Immunization administration through 18 years of age via any</td>
<td>2009</td>
<td>24</td>
<td>0.024</td>
<td>0.17</td>
<td>7</td>
<td>7</td>
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<tr>
<td>SVY</td>
<td>90460</td>
<td>XXX</td>
<td>Immunization administration through 18 years of age via any</td>
<td></td>
<td>94</td>
<td>0.039</td>
<td>0.15</td>
<td>15</td>
<td>2</td>
<td>11</td>
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</tr>
<tr>
<td>REC</td>
<td>90460</td>
<td>XXX</td>
<td>Immunization administration through 18 years of age via any</td>
<td></td>
<td>32</td>
<td>0.034</td>
<td>0.24</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st REF</td>
<td>96375</td>
<td>ZZZ</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify)</td>
<td>2017</td>
<td>23</td>
<td>0.025</td>
<td>0.10</td>
<td>4</td>
<td>4</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>96411</td>
<td>ZZZ</td>
<td>Chemotherapy administration; intravenous, push technique,</td>
<td>2017</td>
<td>22</td>
<td>0.033</td>
<td>0.20</td>
<td>7</td>
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<td>11</td>
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<tr>
<td>CURRENT</td>
<td>90461</td>
<td>ZZZ</td>
<td>Immunization administration through 18 years of age via any</td>
<td>2009</td>
<td>24</td>
<td>0.039</td>
<td>0.15</td>
<td>7</td>
<td>7</td>
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<tr>
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<td>90461</td>
<td>ZZZ</td>
<td>Immunization administration through 18 years of age via any</td>
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<td>32</td>
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<tr>
<td>REC</td>
<td>90461</td>
<td>ZZZ</td>
<td>Immunization administration through 18 years of age via any</td>
<td></td>
<td>32</td>
<td>0.036</td>
<td>0.15</td>
<td>5</td>
<td>5</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1st REF</td>
<td>99211</td>
<td>XXX</td>
<td>Office or other outpatient visit for the evaluation and</td>
<td>2019</td>
<td>23</td>
<td>0.027</td>
<td>0.18</td>
<td>7</td>
<td>5</td>
<td>11</td>
<td>3</td>
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<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>99188</td>
<td>XXX</td>
<td>Application of topical fluoride varnish by a physician or other</td>
<td>2014</td>
<td>21</td>
<td>0.022</td>
<td>0.20</td>
<td>9</td>
<td>2</td>
<td>11</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CURRENT</td>
<td>90471</td>
<td>XXX</td>
<td>Immunization administration (includes percutaneous)</td>
<td>2009</td>
<td>24</td>
<td>0.024</td>
<td>0.17</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SVY</td>
<td>90471</td>
<td>XXX</td>
<td>Immunization administration (includes percutaneous)</td>
<td></td>
<td>100</td>
<td>0.050</td>
<td>0.10</td>
<td>4</td>
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</tr>
<tr>
<td>REC</td>
<td>90471</td>
<td>XXX</td>
<td>Immunization administration (includes percutaneous)</td>
<td></td>
<td>32</td>
<td>0.024</td>
<td>0.17</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The table above includes various codes and descriptions related to immunization administration, with specific details such as years, responses, work per unit time, and total times.
| 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 | Source | CPT | Global | DESC | RUC Review Year | Resp | IWPUT | Work Per Unit Time | RVW | Total | PRE-TIME | INTRA-TIME | IMM | SURVEY EXPERIENCE |
| 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 | 1st REF | 96375 | ZZZ | Therapeutic, prophylactic, or diagnostic injection (specify) | 2017 | 40 | 0.025 | 0.025 | 0.10 | 4 | 4 | | | |
| 18 | 2nd REF | 96411 | ZZZ | Chemotherapy administration; intravenous, push technique. | 2017 | 17 | 0.033 | 0.029 | 0.20 | 7 | 3 | | | |
| 19 | CURRENT | 90472 | ZZZ | Immunization administration (includes percutaneous) | 2009 | | 0.021 | 0.021 | 0.15 | 7 | | | |
| 20 | 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 |
| 21 | REC | 90472 | ZZZ | Immunization administration (includes percutaneous) | 0.021 | 0.021 | 0.15 | 7 | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 33 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 34 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 38 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 39 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 40 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 41 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 42 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 43 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 44 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 45 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 46 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 47 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 48 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 49 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 51 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 53 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 54 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 55 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 56 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 57 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 60 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 61 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 62 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 63 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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   | X   | Y   | Z   | AR | AS | AT | AU | AV |
|---|---|-----|-----|-----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 15| Source | CPT | Global | DESC | RUC Review Year | Resp | WORK UNIT | Time | MIN | 25th | MED | 75th | MAX | Time | EVAL | POSIT | SDW | MIN | 25th | MED | 75th | MAX | POST | MIN | 25th | MED | 75th | MAX | POST |
| 16| 66| Source | CPT | Global | DESC | RUC Review Year | Resp | WORK UNIT | Time | MIN | 25th | MED | 75th | MAX | Time | EVAL | POSIT | SDW | MIN | 25th | MED | 75th | MAX | POST | MIN | 25th | MED | 75th | MAX | POST |
| 67| CURRENT CMS Crosswalk | G0008 | XXX | Administration of influenza virus vaccine | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 68| REC | 90471 | XXX | Immunization administration (includes percutaneous, | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 69| REC | G0008 | XXX | Administration of influenza virus vaccine | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 70| CURRENT CMS Crosswalk | G0009 | XXX | Administration of pneumococcal vaccine | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 71| REC | 90471 | XXX | Immunization administration (includes percutaneous, | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 72| REC | G0009 | XXX | Administration of pneumococcal vaccine | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 73| CURRENT CMS Crosswalk | G0010 | XXX | Administration of hepatitis b vaccine | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 74| REC | 90471 | XXX | Immunization administration (includes percutaneous, | 0.024 | 0.024 | 0.17 | 7 | 7 |
| 75| 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>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</td>
<td>XXX</td>
</tr>
<tr>
<td>90461</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>Counseling is provided when a 15-year-old patient is administered the Human Papilloma virus (HPV) vaccine.</td>
</tr>
<tr>
<td>90461</td>
<td>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.)</td>
</tr>
</tbody>
</table>

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, Pediatrix, 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.
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:
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](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](http://www.bls.gov) 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:
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)

Table:

| McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger single 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 Latitude 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 single 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
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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX</td>
</tr>
<tr>
<td>90472</td>
<td>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)</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td>A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intramuscular injection of seasonal influenza vaccine.</td>
</tr>
<tr>
<td>90472</td>
<td>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.)</td>
</tr>
</tbody>
</table>

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.
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, Pediarex, 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.
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:
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 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:

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:
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 Latitude 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
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

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<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
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<tbody>
<tr>
<td>90473</td>
<td>Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)</td>
<td>XXX</td>
</tr>
<tr>
<td>90474</td>
<td>Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

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<tr>
<th>CPT Code</th>
<th>Vignette</th>
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<tbody>
<tr>
<td>90473</td>
<td>A patient seeks immunization against seasonal influenza. The patient is offered and accepts an intranasal administration of seasonal influenza vaccine.</td>
</tr>
<tr>
<td>90474</td>
<td>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.)</td>
</tr>
</tbody>
</table>

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.
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.
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; 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:
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 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:
   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:
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)

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
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.
<table>
<thead>
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<th>REFERENCE CODE</th>
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<th>RECOMMENDED RATE</th>
<th>MEDICAL SUPPLIES</th>
<th>PRICE</th>
<th>UNIT</th>
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<td>-</td>
</tr>
<tr>
<td>90461</td>
<td>0.5</td>
<td></td>
<td>Vaccine registry input/Refrigerator/freezer temperature log</td>
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</tbody>
</table>

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<tr>
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<th>Clinical</th>
<th>Type Rate</th>
<th>Price Per Minute</th>
<th>Non Fac</th>
<th>Faculty</th>
</tr>
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<tbody>
<tr>
<td>Staff Type</td>
<td>Clinical</td>
<td>Type Rate</td>
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</tr>
</tbody>
</table>

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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 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 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 purchase price estimate consistent with the paid invoice in column D.
A

1 RUC Practice Expense Spreadsheet
2
3
RUC Collaboration Website
Meeting Date: April 2021
Clinical
Revision Date (if applicable):
Activity Code Tab: Immunization Administration
4
Specialties: AAFP, ACOG, ACP, ANA, AAP
LOCATION
5
6
GLOBAL PERIOD
TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND
7
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
Start: Following visit when decision for surgery/procedure made
14
15
CA001
16
CA002
17
CA003
18
CA004
19
CA005
20
CA006
21
CA007
22
CA008
27
End: When patient enters office/facility for surgery/procedure
28
SERVICE PERIOD
Start: When patient enters office/facility for surgery/procedure:
29
30
Pre-Service (of service period)
31
CA009
32
CA010
33
CA011
34
CA012
35
CA013
36
CA014
37
CA015
CA016
38
CA017
39
40
43
OLD
Review charts
46
Intra-service (of service period)
CA018
47
CA019
48
CA020
49
CA021
50
53
54
57
Post-Service (of service period)
58
CA022
CA023
59
CA024
60
CA025
61
CA026
62
CA027
63
CA028
64
65
CA029
CA030
66
67
CA031
CA032
68
CA033
69
CA034
70
CA035
71
CA036
72
73
76
OLD
Vaccine registry input/Refrigerator/freezer temperature log
77
78
Other activity: please include short clinical description here and type new
79
End: Patient leaves office/facility
80
POST-SERVICE PERIOD
81
Start: Patient leaves office/facility
CA037
82
83
CA038
84
Office visits: List Number and Level of Office Visits
85
99211 16 minutes
86
99212 27 minutes
87
99213 36 minutes
88
99214 53 minutes
89
99215 63 minutes
90
CA039
91
94
Other activity: please include short clinical description here and type new
97
End: with last office visit before end of global period
98 Supply Code MEDICAL SUPPLIES
99
TOTAL COST OF SUPPLY QUANTITY x PRICE
100
SC058
101
SJ053
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SB022
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SG021
SK012
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SK057
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SB036
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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.
Equipment
Code
ED043
EF040
NEW
EF023

EQUIPMENT
TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE
refrigerator, vaccine medical grade, w-data logger sngl glass door

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.

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**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)

<table>
<thead>
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<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>90471</strong></td>
<td>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</td>
<td>13 minutes (Nonfacility) (NF) 1 minute Review charts 3 minutes F/u on physician’s discussion with patient/parent &amp; 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</td>
<td>4 minutes NF*</td>
<td>13 + 4 = 17 minutes NF 3 minutes F</td>
<td></td>
</tr>
<tr>
<td><strong>90472</strong></td>
<td>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</td>
<td>7 minutes (Nonfacility) (NF) 3 minutes F/u on physician’s discussion with patient/parent &amp; obtain actual consent signature 2 minutes Draw up serum; administer vaccine</td>
<td>1 minute NF*</td>
<td>7 + 1 = 8 minutes NF</td>
<td></td>
</tr>
<tr>
<td>2 minutes Record vaccine information (lot number, manufacturer, VIS information)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
</tbody>
</table>

| 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)

|---|---|---|---|---|
| 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) | 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) | 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) |
<table>
<thead>
<tr>
<th></th>
<th>SB036 paper, exam table (7)</th>
<th>SK012 CDC information sheet (1)</th>
<th>SB022 gloves, non-sterile (1 pair)</th>
<th>SJ053 swab-pad, alcohol (2)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90473</td>
<td>SB036 paper, exam table (7)</td>
<td>SK012 CDC information sheet (1)</td>
<td>SB022 gloves, non-sterile (1 pair)</td>
<td>SJ053 swab-pad, alcohol (2)</td>
<td>SB036 paper, exam table (7)</td>
</tr>
<tr>
<td>90474</td>
<td>SK012 CDC information sheet (1)</td>
<td>SJ053 swab-pad, alcohol (2)</td>
<td>SK012 CDC information sheet (1)</td>
<td>SJ053 swab-pad, alcohol (2)</td>
<td></td>
</tr>
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</table>

**Medical Equipment (Nonfacility (NF) Only)**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90471</td>
<td>13 minutes</td>
<td>EF023 table, exam</td>
<td>17 minutes**</td>
<td>EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates</td>
<td>13 minutes exam table 17 minutes fridge monitor/alarm</td>
</tr>
<tr>
<td>90472</td>
<td>7 minutes</td>
<td>EF023 table, exam</td>
<td>8 minutes**</td>
<td>EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates</td>
<td>7 minutes exam table 8 minutes fridge monitor/alarm</td>
</tr>
<tr>
<td>90473</td>
<td>17 minutes**</td>
<td>EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates</td>
<td>17 minutes fridge monitor/alarm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90474</td>
<td>8 minutes**</td>
<td>EF040 refrigerator, vaccine, commercial grade, w-alarm lock ED043 refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates</td>
<td>8 minutes fridge monitor/alarm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.
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.
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. “Diagnostic dark adaptation examination with interpretation and report.”

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>92284</td>
<td>Dark adaptation examination with interpretation and report</td>
<td>XXX</td>
<td>0.14</td>
</tr>
</tbody>
</table>
CPT Code: 92284

AMERICAN MEDICAL ASSOCIATION

SUMMARY OF RECOMMENDATION

CPT Code: 92284

Tracking Number

Original Specialty Recommended RVU: 0.24

Presented Recommended RVU: 0.17

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

**CPT Code:** 92284

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presenter(s):</strong></td>
<td>David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); John T. Thompson, MD (ASRS); Charles Fitzpatrick, OD (AOA)</td>
</tr>
<tr>
<td><strong>Specialty Society(ies):</strong></td>
<td>American Academy of Ophthalmology (AAO), American Society of Retina Specialists (ASRS); American Optometric Association (AOA)</td>
</tr>
<tr>
<td><strong>CPT Code:</strong></td>
<td>92284</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>3069</td>
</tr>
<tr>
<td><strong>Resp N:</strong></td>
<td>45</td>
</tr>
</tbody>
</table>

**Description of Sample:** Random sample of US practicing members of AAO, ASRS, and AOA

<table>
<thead>
<tr>
<th><strong>Service Performance Rate</strong></th>
<th>Low</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>Median*</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survey RVW:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>2.00</td>
<td>11.25</td>
<td>1000.00</td>
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<tr>
<td><strong>Pre-Service Evaluation Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>5.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>1.00</td>
<td>10.00</td>
<td>15.00</td>
<td>20.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:** 10.00

**Post Operative Visits | Total Min** | CPT Code and Number of Visits |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical Care time/visit(s):</strong></td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td><strong>Other Hospital time/visit(s):</strong></td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td><strong>Discharge Day Mgmt:</strong></td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td><strong>Office time/visit(s):</strong></td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td><strong>Prolonged Services:</strong></td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td><strong>Sub Obs Care:</strong></td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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)

**Specialty Recommended Pre-Time:**

**Adjustments/Recommended Pre-Service Time**

### CPT Code: 92284

<table>
<thead>
<tr>
<th><strong>Recommended Physician Work RVU:</strong></th>
<th>0.14</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Pre-Service Evaluation Time:</strong></th>
<th>1.00</th>
<th>0.00</th>
<th>1.00</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service Positioning Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Pre-Service Scrub, Dress, Wait Time:</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Intra-Service Time:</strong></td>
<td>3.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immediate Post Service-Time:**

**Specialty Recommended Post-Time:**

**Adjustments/Recommended Post-Service Time**

<table>
<thead>
<tr>
<th><strong>Immediate Post Service-Time:</strong></th>
<th>1.00</th>
<th>0.00</th>
<th>1.00</th>
</tr>
</thead>
</table>

**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)**

**Specialty Recommended Post-Time:**

**Adjustments/Recommended Post-Service Time**

<table>
<thead>
<tr>
<th><strong>Immediate Post Service-Time:</strong></th>
<th>1.00</th>
<th>0.00</th>
<th>1.00</th>
</tr>
</thead>
</table>

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**Note:** 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 (16); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)
<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.00 99239x 0.00 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
<td>0.00</td>
<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>92083</td>
<td>XXX</td>
<td>0.50</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

CPT Descriptor: Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., 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:**

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>92134</td>
<td>XXX</td>
<td>0.45</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>93010</td>
<td>XXX</td>
<td>0.17</td>
<td>RUC Time</td>
<td>18,866,949</td>
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</table>

CPT Descriptor 1: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

<table>
<thead>
<tr>
<th>MPC CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>73120</td>
<td>XXX</td>
<td>0.16</td>
<td>RUC Time</td>
<td>278,753</td>
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</tbody>
</table>

CPT Descriptor 2: Radiologic examination, hand; 2 views

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>93000</td>
<td>XXX</td>
<td>0.17</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

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%

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 92284</th>
<th>Top Key Reference CPT Code: 92083</th>
<th>2nd Key Reference CPT Code: 92134</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>1.00</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>4.00</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>6.00</td>
<td>13.00</td>
<td>11.00</td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>14%</td>
<td>45%</td>
<td>32%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Mental Effort and Judgment

- 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

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27%</td>
<td>32%</td>
<td>41%</td>
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</tbody>
</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18%</td>
<td>50%</td>
<td>32%</td>
</tr>
</tbody>
</table>
CPT Code: 92284

| Physical effort required | 18% | 68% | 14% |

**Psychological Stress**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>18%</td>
<td>55%</td>
<td>27%</td>
</tr>
</tbody>
</table>

- 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

**Survey Code Compared to 2nd Key Reference Code**

<table>
<thead>
<tr>
<th>Overall intensity/complexity</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Effort and Judgment**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>25%</td>
<td>38%</td>
</tr>
</tbody>
</table>

- 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

**Technical Skill/Physical Effort**

<table>
<thead>
<tr>
<th>Technical skill required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>38%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>50%</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>

**Psychological Stress**

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>75%</td>
<td>0%</td>
</tr>
</tbody>
</table>

| 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 |

---

**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.

<table>
<thead>
<tr>
<th>Data Acquisition</th>
<th>All (n=29)</th>
<th>MD (n=16)</th>
<th>OD (n=13)</th>
<th>Performers (n=18)</th>
<th>Non Performers (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tech/Staff</td>
<td>23</td>
<td>15</td>
<td>8</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Provider</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global Period</th>
<th>Work RVU</th>
<th>Pre</th>
<th>Intra</th>
<th>Post</th>
<th>% Billed Together</th>
</tr>
</thead>
<tbody>
<tr>
<td>92250</td>
<td>XXX</td>
<td>0.40</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>34.8%</td>
</tr>
<tr>
<td>92014</td>
<td>XXX</td>
<td>1.42</td>
<td>5</td>
<td>24</td>
<td>8</td>
<td>30.1%</td>
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<tr>
<td>92134</td>
<td>XXX</td>
<td>0.45</td>
<td>1</td>
<td>10</td>
<td></td>
<td>26.7%</td>
</tr>
<tr>
<td>92083</td>
<td>XXX</td>
<td>0.50</td>
<td>3</td>
<td>10</td>
<td></td>
<td>24.7%</td>
</tr>
<tr>
<td>99213</td>
<td>XXX</td>
<td>1.30</td>
<td>5</td>
<td>20</td>
<td>5</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

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
## Dark Adaptation Eye Exam (CPT 92284)

<table>
<thead>
<tr>
<th>Source</th>
<th>CPT</th>
<th>Global</th>
<th>DESC</th>
<th>Year</th>
<th>Resp</th>
<th>INPUT</th>
<th>Time</th>
<th>RWW</th>
<th>Total</th>
<th>PRE</th>
<th>INTRA</th>
<th>IMMD</th>
<th>FAC-inpt/same day</th>
<th>Office</th>
<th>SURVEY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st REF</td>
<td>92083</td>
<td>XXX</td>
<td>Visual field ex 2012</td>
<td>22</td>
<td>0.043</td>
<td>0.038</td>
<td>0.50</td>
<td></td>
<td>13</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd REF</td>
<td>92134</td>
<td>XXX</td>
<td>Scanning con 2015</td>
<td>8</td>
<td>0.043</td>
<td>0.041</td>
<td>0.45</td>
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<td>11</td>
<td>1</td>
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</tr>
<tr>
<td>CURRENT</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation N/A - Harvard</td>
<td></td>
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<td>0.007</td>
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<td>0.24</td>
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<td>36</td>
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<tr>
<td>SVY</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation</td>
<td>45</td>
<td>0.011</td>
<td>0.017</td>
<td>0.15</td>
<td>0.45</td>
<td>0.50</td>
<td>0.60</td>
<td>1.25</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SVY - MD</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation</td>
<td>29</td>
<td>0.009</td>
<td>0.016</td>
<td>0.15</td>
<td>0.48</td>
<td>0.50</td>
<td>0.60</td>
<td>1.25</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SVY - OD</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation</td>
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<td>0.011</td>
<td>0.017</td>
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<tr>
<td>SVY - PERFORM ERS</td>
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<td>XXX</td>
<td>Dark adaptation examination with</td>
<td>24</td>
<td>0.011</td>
<td>0.017</td>
<td>0.27</td>
<td>0.49</td>
<td>0.50</td>
<td>0.63</td>
<td>1.25</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SVY - NON PERFORM ERS</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation examination with</td>
<td>21</td>
<td>0.011</td>
<td>0.017</td>
<td>0.15</td>
<td>0.45</td>
<td>0.50</td>
<td>0.55</td>
<td>0.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SVY - EXCLUDE PERFORM ERS &gt; 1000</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation examination with interpretation and report</td>
<td>44</td>
<td>0.010</td>
<td>0.016</td>
<td>0.15</td>
<td>0.47</td>
<td>0.50</td>
<td>0.61</td>
<td>1.25</td>
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<td></td>
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<tr>
<td>REC</td>
<td>92284</td>
<td>XXX</td>
<td>Dark adaptation examination with interpretation and report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XWALK</td>
<td>76514</td>
<td>XXX</td>
<td>Ophthalmic ultrasound, 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>1</td>
<td></td>
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</tbody>
</table>
Meeting Date: April 2021

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>92284</td>
<td>Dark adaptation examination with interpretation and report</td>
<td>XXX</td>
</tr>
</tbody>
</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>92284</td>
<td>A 55 year old female with poor night vision has no identifiable cause on examination. Dark adaptation is performed to assess retinal function.</td>
</tr>
</tbody>
</table>

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
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](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](http://www.bls.gov) 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 Latitude 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.
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<tr>
<td>LOCATION</td>
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</tr>
<tr>
<td>7</td>
<td>TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>8</td>
<td>TOTAL CLINICAL STAFF TIME</td>
<td>LO38A</td>
<td>69.0</td>
<td>0.0</td>
<td>26.0</td>
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<tr>
<td>9</td>
<td>TOTAL PRE-SERVICE CLINICAL STAFF TIME</td>
<td>LO38A</td>
<td>8.0</td>
<td>0.0</td>
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<tr>
<td>10</td>
<td>TOTAL SERVICE PERIOD CLINICAL STAFF TIME</td>
<td>LO38A</td>
<td>61.0</td>
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<td>11</td>
<td>TOTAL POST-SERVICE CLINICAL STAFF TIME</td>
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</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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@aaao.org.

Sincerely,

Michael X. Repka, MD, MBA
AAO Medical Director for Government Affairs
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.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
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.**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>Work RVU Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>92287</td>
<td>Anterior segment imaging with interpretation and report; with fluorescein angiography</td>
<td>XXX</td>
<td>0.40</td>
</tr>
</tbody>
</table>
CPT Code: 92287

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 92287  Tracking Number
Global Period: XXX  Current Work RVU: 0.81

Original Specialty Recommended RVU: 0.40
Presented Recommended RVU: 0.40
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**

<table>
<thead>
<tr>
<th>RUC Meeting Date (mm/yyyy)</th>
<th>04/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenter(s):</td>
<td>Ankoor R. Shah, MD (AAO); David B. Glasser, MD (AAO); John T. Thompson, MD (ASRS)</td>
</tr>
<tr>
<td>Specialty Society(ies):</td>
<td>American Academy of Ophthalmology (AAO), American Society of Retina Specialists (ASRS)</td>
</tr>
<tr>
<td>CPT Code:</td>
<td>92287</td>
</tr>
</tbody>
</table>

| Sample Size: | 2075 |
| Resp N:      | 30 |

**Description of Sample:** Random sample of US practicing ophthalmologists of AAO and AOA

<table>
<thead>
<tr>
<th>Low</th>
<th>25th pctl</th>
<th>Median*</th>
<th>75th pctl</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Performance Rate</td>
<td>0.00</td>
<td>2.00</td>
<td>5.00</td>
<td>9.00</td>
</tr>
<tr>
<td>Survey RVW:</td>
<td>0.40</td>
<td>0.70</td>
<td>0.75</td>
<td>0.80</td>
</tr>
<tr>
<td>Pre-Service Evaluation Time:</td>
<td>5.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Positioning Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service Scrub, Dress, Wait Time:</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Service Time:</td>
<td>1.00</td>
<td>6.00</td>
<td>10.00</td>
<td>15.00</td>
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</tbody>
</table>

**Immediate Post Service-Time:** 10.00

**Post Operative Visits**

<table>
<thead>
<tr>
<th>CPT Code and Number of Visits</th>
<th>Total Min**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
</tr>
<tr>
<td>Office time/visit(s)</td>
<td>0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Obs Care</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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

| Pre-Service Evaluation Time: | 1.00 |
| Pre-Service Positioning Time: | 0.00 |
| Pre-Service Scrub, Dress, Wait Time: | 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 |

| Immediate Post Service-Time: | 1.00 | 0.00 | 1.00 |

---

**Low** refers to the lowest observed value, **25th pctl** refers to the 25th percentile, **Median** refers to the median, **75th pctl** refers to the 75th percentile, and **High** refers to the highest observed value. **E/M visit** refers to Evaluation and Management visit.

**Physician standard total minutes per E/M visit:** 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99217 (38); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (40); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)
### CPT Code: 92287

<table>
<thead>
<tr>
<th>Post-Operative Visits</th>
<th>Total Min**</th>
<th>CPT Code and Number of Visits</th>
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</thead>
<tbody>
<tr>
<td>Critical Care time/visit(s):</td>
<td>0.00</td>
<td>99291x 0.00 99292x 0.00</td>
</tr>
<tr>
<td>Other Hospital time/visit(s):</td>
<td>0.00</td>
<td>99231x 0.00 99232x 0.00 99233x 0.00</td>
</tr>
<tr>
<td>Discharge Day Mgmt:</td>
<td>0.00</td>
<td>99238x 0.0 99239x 0.0 99217x 0.00</td>
</tr>
<tr>
<td>Office time/visit(s):</td>
<td>0.00</td>
<td>99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00</td>
</tr>
<tr>
<td>Prolonged Services:</td>
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<td>99354x 0.00 55x 0.00 56x 0.00 57x 0.00</td>
</tr>
<tr>
<td>Sub Obs Care:</td>
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<td>99224x 0.00 99225x 0.00 99226x 0.00</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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</thead>
<tbody>
<tr>
<td>92235</td>
<td>XXX</td>
<td>0.75</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**CPT Descriptor** Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

### SECOND HIGHEST KEY REFERENCE SERVICE:

<table>
<thead>
<tr>
<th>Key CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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<tbody>
<tr>
<td>92240</td>
<td>XXX</td>
<td>0.80</td>
<td>RUC Time</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>MPC CPT Code 1</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
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<tbody>
<tr>
<td>92250</td>
<td>XXX</td>
<td>0.40</td>
<td>RUC Time</td>
<td>3,490,129</td>
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</table>

**CPT Descriptor 1** Fundus photography with interpretation and report

<table>
<thead>
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<th>MPC CPT Code 2</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
<th>Medicare Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>92082</td>
<td>XXX</td>
<td>0.40</td>
<td>RUC Time</td>
<td>122,984</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Other Reference CPT Code</th>
<th>Global</th>
<th>Work RVU</th>
<th>Time Source</th>
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</thead>
<tbody>
<tr>
<td>92201</td>
<td>XXX</td>
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<td>RUC Time</td>
</tr>
</tbody>
</table>

**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:
CPT Code: 92287

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%

<table>
<thead>
<tr>
<th>TIME ESTIMATES (Median)</th>
<th>CPT Code: 92287</th>
<th>Top Key Reference CPT Code: 92235</th>
<th>2nd Key Reference CPT Code: 92240</th>
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<tbody>
<tr>
<td>Median Pre-Service Time</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Median Intra-Service Time</td>
<td>10.00</td>
<td>15.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Median Immediate Post-service Time</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Median Critical Care Time</td>
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<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Other Hospital Visit Time</td>
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<td>0.0</td>
</tr>
<tr>
<td>Median Discharge Day Management Time</td>
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<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Office Visit Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prolonged Services Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Subsequent Observation Care Time</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Total Time</td>
<td>12.00</td>
<td>17.00</td>
<td>22.00</td>
</tr>
</tbody>
</table>

INTENSITY/COMPLEXITY MEASURES  
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<table>
<thead>
<tr>
<th>Survey Code Compared to Top Key Reference Code</th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intensity/complexity</td>
<td>0%</td>
<td>11%</td>
<td>56%</td>
<td>28%</td>
<td>6%</td>
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</tbody>
</table>

Mental Effort and Judgment

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>22%</td>
<td>39%</td>
<td>39%</td>
</tr>
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</table>

Technical Skill/Physical Effort

<table>
<thead>
<tr>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>6%</td>
<td>61%</td>
<td>33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical effort required</th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>89%</td>
<td>11%</td>
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</tbody>
</table>
## Psychological Stress

<table>
<thead>
<tr>
<th></th>
<th>Less</th>
<th>Identical</th>
<th>More</th>
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</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>61%</td>
<td>39%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
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## Survey Code Compared to 2nd Key Reference Code

### Overall intensity/complexity

<table>
<thead>
<tr>
<th></th>
<th>Much Less</th>
<th>Somewhat Less</th>
<th>Identical</th>
<th>Somewhat More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
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## Mental Effort and Judgment

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<thead>
<tr>
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<tbody>
<tr>
<td>The number of possible diagnosis and/or the number of management options that must be considered</td>
<td>20%</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td>
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<tr>
<td>Urgency of medical decision making</td>
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## Technical Skill/Physical Effort

### Technical skill required

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<tr>
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### Physical effort required

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## Psychological Stress

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<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
<td>0%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Outcome depends on the skill and judgment of physician</td>
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<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
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</table>

### 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 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Global Period</th>
<th>Work RVU</th>
<th>Pre</th>
<th>Intra</th>
<th>Post</th>
<th>% Billed Together</th>
</tr>
</thead>
<tbody>
<tr>
<td>92287</td>
<td>XXX</td>
<td>0.75</td>
<td>1</td>
<td>15</td>
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<td>86.7%</td>
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<td>92250</td>
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<td>0.40</td>
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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.

<table>
<thead>
<tr>
<th>Specialty Ophthalmology</th>
<th>Frequency 14000</th>
<th>Percentage 100.00 %</th>
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<tbody>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage %</td>
</tr>
<tr>
<td>Specialty</td>
<td>Frequency</td>
<td>Percentage %</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialty Ophthalmology</th>
<th>Frequency 8500</th>
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CPT Code: 92287

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<tr>
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<td>0.00 %</td>
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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
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</table>
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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Global Period</th>
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<tbody>
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<td>Anterior segment imaging with interpretation and report; with fluorescein angiography</td>
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</table>

Vignette(s) (vignette required even if PE only code(s)):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vignette</th>
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<tbody>
<tr>
<td>92287</td>
<td>A 67 year old diabetic male has possible iris neovascularization. Fluorescein angiography is performed.</td>
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</tbody>
</table>

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
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.
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:

   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
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 Latitude 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:
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).

<table>
<thead>
<tr>
<th>Itemized List of Changes</th>
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<tbody>
<tr>
<td><em>obtain vital signs</em> was reduced from 5 minutes to 3 minutes</td>
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</table>

**NOTE:** The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.
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<th>C</th>
<th>D</th>
<th>E</th>
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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 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.